ASSESS THE REPRODUCTIVE HEALTH PROBLEMS AMONG MIGRANT WOMEN POPULATION AT SELECTED SETTING, THIRUVALLUR DISTRICT, 2016.

DISSERTATION SUBMITTED TO

THE TAMIL NADU Dr.M.G.R. MEDICAL UNIVERSITY,

CHENNAI

IN PARTIAL FULFILLMENT OF REQUIREMENT FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

OCTOBER 2016

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LIST OF ABBREVIATIONS

CBPR	-	Community based participatory research
COMIRES	-	COmmunity Migrant RESearch
HIV	-	Human Immune Virus
HOD	-	Head of the Department
ICCR	-	International Centre for Collaborative Research
ICPD	-	International Conference Population Development
MEDLINE	-	Medical Literature Analysis and Retrieval
NPP	-	National Population Policy
PHC	-	Primary Health Centre
RCH	-	Reproductive and Child Health
UNMDG	-	The United Nations Millennium Development
WHO	-	World Health Organization

LIST OF SYMBOLS

=	**-**	**Equals to**
>	**-**	**More than**
%	**-**	**Percentage**
C.I	**-**	**Confidence Interval**
N	**-**	**Total number of samples**
P	**-**	**Significance**

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ABSTRACT

Assess the reproductive health problems among migrant women population at selected setting, Thiruvallur.

Aim and objective: To assess the reproductive health problems among migrant women population in temporary settlement area. **Methodology:** Non experimental descriptive research design was adopted to assess the reproductive health problems among migrant women population at Pinjivakkam, Thiruvallur District. 100 migrant women who satisfied the inclusion criteria were selected by non- probability convenient sampling technique and the data were collected using Structured interview schedule. **Results:** The finding of study revealed there productive health problems among migrant women such as menstrual irregularity (52%), reproductive tract infection (47%), urinary incontinence (57%) anemia(83%) and breast problems(43%) was identified. **Conclusion:** The researcher identified the various reproductive health problems among migrant women. The study findings revealed that the selected risk factors shows statistically significant of odds ratio. The researcher recommended that mass awareness and screening programme can be initiated to reduce the magnitude of reproductive health problems among migrant women.

Keywords: *migrant women population, reproductive health problems, precipitating factors*

INTRODUCTION

A woman is an epitome of love, sacrifice and possesses the ability to nurture life, which makes her the most powerful and strongest being in the world. Woman is worshipped next to God in our cultural perspective because, woman is the one who gives birth to generations and bear live offspring. The organs and structures of female reproductive system give the woman the ability to produce a new life. Since the female reproductive system plays an important role throughout the life of a woman.

Reproductive health is an important aspect of women's life which functions at all stages of life. It implies that people should be responsible, satisfying and give importance to reproductive health. Although women health issues have attained higher international visibility and renewed programs have enabled women to lead healthier lives, significant gender-based health disparities remain in many countries, particularly the migrant women population. The migrant women population is a group of people move from place to another frequently for their survival. They vary due to social, economic and political reasons. The

main occupation of the people who originally belong to indigenous tribes is hunting and selling beaded ornaments to survive. With limited access to education or employment, high illiteracy rates and increasing poverty levels are making health improvements for women exceedingly difficult. Health-related challenges basic health care, family planning and obstetric services are essential for women yet they remain unavailable to millions. Because of poor environmental conditions, low socio-economic status and lack of awareness; migrant women are more prone to get affected when comparing to normal reproductive age women.

This affects the health of the migrant women and prevents them from utilization of health services leading to various issues most commonly the reproductive health problems. Hence the investigator was interested in identifying the reproductive health problems and its precipitating factors among migrant woman.

OBJECTIVES

1. To assess the reproductive health problems among migrant woman population.
2. To identify the precipitating factors for reproductive health problems among migrant women population.

METHODOLOGY

A Non-experimental descriptive research design was adopted to assess the reproductive health problems among migrant woman at selected setting, Thiruvallur. The sample size consisted of 100migrant women who fulfilled the inclusion and exclusion criteria who were selected through non probability purposive sampling technique.The study was conducted at migrant's temporary settlement area at Pinjivakkam, Thiruvallur district which covers about 500 migrant populations among 232 were migrant women between the age group of 15-44 years.

The tool consisted of 2 parts, demographic variables and structured interview schedule to assess the reproductive health problems.

RESULTS AND DISCUSSION

The study findings revealed that migrant women experienced reproductive health problems such as menstrual irregularity (52%), reproductive tract infection (47%), urinary incontinence (56%), anaemia (85%) and breast problems (43%) was identified. Precipitating factors for each problem was identified. Women in the age group of (35-39) years, (40-44) years, who were Christians, who had 6-7 days duration of menstruation, with 20 years of duration of marital life, first child birth in the age of 18-21 years and history of legal abortion had menstrual irregularities. Women between (30-34) years of age, using waste cloth during menstruation with the history of legal abortion, having coitus more than 5 times/week, using temporary contraceptive devices had reproductive tract infection. Women between (40-44) years of age had irregular menstrual cycle (abnormal heavy bleeding), who experienced more than 20 years of marital life with practice of coitus more than 5 times/week has urinary incontinence. Women between (30-34) years (25-29) years of age, belonging to Hindu religion, who follows bland diet during menstruation as a cultural practice had anemia. Women between the age (25-29) years, skilled worker (selling beads),with history of regular menstrual cycle (31-35),in the duration of (6-7) days of menstruation, first child birth in the age of (18-21), history of abortion, who had coitus more than 5 times/week, using contraceptive measures temporary had breast problems.

IMPLICATIONS

The Nurse midwives have a vital role to play in improving the reproductive health outcome. The researcher will utilize the research findings of the study, to plan regular and periodical health screening in the migrant areas through the community health centers at Pinjivakkam. The Nurse Educator has the role in incorporating the evidence based guidelines into the nursing curriculum for improving the reproductive health among migrant population. The Nurse Administrator should collaborate with the Government and Non-Governmental organizations to create policies and conduct awareness campaign programme among migrant women. The Nurse Researcher Should publishes the findings of the study through paper/poster presentation in conferences, seminars and workshops.

CONCLUSION

The investigator identified various reproductive health problems and its precipitating factors among migrant women. The study findings serve as a core value to device appropriate nursing and health care services through which the reproductive health problems can be reduced and to promote wellbeing and transformation in the human related life style among migrant women.

CHAPTER – 1

INTRODUCTION

INTRODUCTION

Women's health is considered as the fundamental human right and a worldwide social quality of life. A healthy woman is an asset to the society and they are the basic foundation of a society and its wealth. Around the globe, women plays very crucial role in the family, community, and Nation as whole, are starting from child birth, to performing everyday activities. A woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by effects of work load, nutrition, stress, war and migration. Some health challenges affect men and women but, these changes have a greater or different impact on women, as they require responses that are tailored specifically to women's needs. Women's health matters not only to women themselves and it's also to the entire world.

Although Women's health issues have attained higher international visibility and renewed programs have enabled women to lead healthier lives, significant gender-based health disparities remain in many countries. With limited access to education or employment, high illiteracy rates and increasing poverty levels are making health improvements for women exceedingly difficult. Health-related challenges are basic health care, family planning and obstetric services are essential for women yet they remain unavailable to millions. Gender-equitable approaches to health are needed to enable women's full participation in the planning and delivery of health services.

Hence the women need to focus health particularly in reproductive health, as it became universal concern, and is of special importance for women particularly during reproductive years.

According to International Conference Population Development(ICPD) Reproductive health is a state of complete physical, mental and social well-being and not merely an absence of reproductive diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes. Therefore, the women's right is to be informed of and to have access to safe, effective, affordable and acceptable methods of reproductive health of their choice, and the right to access appropriate health care services that will enable women free from diseases. Women in higher income

countries have lower levels of mortality and burden of disease than those who live in lower income countries. So the women who are living in very low socio economic status without having any facilities are prone to get more reproductive health problems.

In the 21st century urbanization, globalization are the new trends, despite which the migrant community does not in pace with it. Among migrant population who is called by Narikuravar, originally belong to the indigenous tribes, the main occupation of the people is hunting and selling beaded ornaments. The major issues of migrants in India is determined by backwardness in terms of ideas of development, isolation , living in inaccessible areas and their shifting cultivation, so the migrant women have significant unique health needs, concerns and challenges, due to poverty and illiteracy. In particularly they are more prone to get reproductive health problems.

Common reproductive health problems affecting women includes menstrual irregularity, endometriosis, uterine fibroids, gynaecology cancer, polycystic ovarian cancer, unsafe abortion, sexual transmitted diseases, sexual violence and infertility. Because of poor environment, low socio-economic status and lack of awareness migrant women are more prone to get affected when comparing to normal reproductive age women.

Hence health care professionals must provide health care to these migrant women focusing on sexual health concerns and problems, contraceptive use and utilisation of other reproductive health services. As a solution, nurses must involve in early detection and screening to prevent reproductive health problems among the migrant women. In addition to routine medical care, counselling and education related to sexual and reproductive family health is also required.

1.1.1 BACKGROUND OF THE STUDY

Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years. Although most reproductive health problems arise during their productive years, in old age general health continues to reflect and crucial during adolescence and adulthood. Reproductive health problems can be harmful to overall health and emotional well-being and can make it hard to enjoy a sexual relationship. Fortunately, many reproductive health problems can be prevented or

corrected if identified or screened early. So the reproductive health is the first and foremost health care need of women. (Economic and Social Commission for Asia and Pacific 2009)

Despite some progress, considerable challenges continue to exist in the area of the sexual and reproductive health. Reproductive health problems are the leading cause of women's ill health and death worldwide. Death and disability due to sexual and reproductive health accounted for 18 per cent of the total disease burden globally and 32 per cent of the disease burden among women of reproductive age (Economic and Social Commission for Asia and Pacific 2014).In the other hand, maternal conditions were the second most leading causes of death among women. More than 99 percent of the estimated 536,000 maternal deaths occur every year in the developing world. Every year, about 10 million women endure life-threatening complications during pregnancy and childbirth. Globally, a woman affected by HIV/AIDS is plunged further into poverty, early and unwanted childbearing, other sexually transmitted infections, and deaths account for a significant proportion of the burden of illness experienced by women especially the migrant women population who were in the remote areas and have very low-income status.

In general, remote areas do not have access to affordable health care services. The barriers that prevent migrant women from utilising reproductive health care services are similar to those found in general health services. Additional hurdles include lack of knowledge, embarrassment, fear and discomfort, lack of motivation from a regular health care provider and inability to provide continuity of services when patients are on the move.

In the 21st century, majority of the population from Europe found that migrant women continue to have reproductive health problems and extreme poverty which will be 10 times bigger than of the surrounding populations

Globally, there are 1 million migrants in France, 800,000 in Sprain, 300,000 in great Britain, more than 300,000 in Greece, Europe is now about 10 million. (National population policy).

As per 2011 census in India, the total migrant population is about 10.43 crore, constituting 8.6% of the total population. 89.97% of them live in rural areas and 10.03% in urban areas. Sex ratio is about 940 females/1000 males.

Table 1.1.1 State level estimation of migrant populations

S.No	Population	No of population(in hundred
1	Tamilnadu	15,000
2	Karnataka	10.000
3	Maharastra	8000
4	Andrapradesh	5000
5	Chennai	4000
6	Thiruvallur	500

Source: WHO, 2011 Census

Recent studies suggest that in India the migrant women are at risk of reproductive health problems such as unhealthy sexual practices, menstrual irregularity, poor personal hygiene, menstrual hygiene, unsafe abortion, family planning methods.

In Global scenario of migrants stated in 2013, the incidence rate of Reproductive tract infection was25%, and in National level it was 15%. Among that the incidence rate of Leucorrhea was 18%, bacterial vaginosis 5.9%, candidiasis 6.1%; Unsafe abortion in the same year was 86% and the Infertility rate was 10-15%. Menstrual irregularity in India was 20%, in Tamilnadu 28%, and particularly in Chennai 18%. In Tamilnadu, the incidence rate of urinary incontinence was 25% and it was commonly seen in women with high parity and anemia was 40-45 %.(Center for disease control 2011).

According to Tamas Berezkel and R. IM Dunbar, (2013),in their cross sectional community surveyassessed the reproductive health issues and significantly determined that frequency of abortion, sex ratio at birth, duration of breast feeding and length of education were the frequent issues among the migrant women.

According to World Health Organization (WHO) each country should take action on migrant sensitive health policies and practices to promote migrant health**.**

1.2 NEED AND SIGNIFICANCE OF THE STUDY

Women are an epitome of love, sacrifice and possess the ability to nurture life, which makes her the most powerful and strongest being. This is especially true for migrant women, women in refugee camps, whose reproductive health needs, are often overlooked. Reproductive health affects the broader context of migrant women, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live.

Bandana Sachdev (2014) Conducted a cross sectional study to assess the vulnerability of reproductive health problem among 1113 migrant married woman at Rajasthan by using convenient sampling technique.The findings of the study showed that reproductive tract infection, menstrual problems and anemia are the common reproductive health problemssignificant association of risk factors such as low socio economic status, poor personal hygiene and poor educationwith reproductive health problems

Sanitasharma (2011) also insisted that reproductive health should also address issues such as harmful sexual practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases, HIV/AIDS, infertility, malnutrition, anemia, and reproductive tract cancers.

George, Rohan Patel et,al (2014)conducted a cross sectional study, assessed the prevalence of reproductive health problems among migrant women between the age group of 15-44 years. The findings revealed that migrant women are vulnerable to poor reproductive health due to lack of awareness. The study also extended that 73% of the unmarried women and 42% of the married women had menstrual irregularity, prevalence of poor nutritional status, higher levels of morbidity and mortality and low utilization of health services among migrants.

Geetha Mani et al, (2013) Fred Hutchinson et al, (2014), conducted a cross-sectional descriptive study to assess the reproductive tract infection among migrant women of age group 18-45 years in rural area, using random sampling teachnique. The study found that extreme poverty and neglect over generations lead to poor state of

health and nutrition. The study revealed that most of the women experienced symptoms of reproductive tract infection such as itching, lower abdominal pain

WHO developed a report on the health of the migrants, which was discussed by the sixty-first world health assembly in May 2011.The resolution asks member states for migrants sensitive health policies and practices and request the WHO to promote migrant health in collaboration with other relevant organizations, encourage inter regional and international co-operation to promote the exchange of information among its members with particular attention to strengthen the health care system of the migrants. The United Nations Millennium Development Goals (MDG's) Goal 5 is to improve maternal health by 2015, with the ultimate aim to prevent the reproductive health problems.

There is a need to provide appropriate services to the people and it should be accessible and must include information, education, counselling, prevention, detection and management of health problems and, rehabilitation. Develop and implement policies that recognize and insist on the respect of the rights of women.

On the other side the WHO was working on additional indicators for global monitoring in reproductive health, including incidence and prevalence of sexually transmitted diseases, prevalence of reproductive health, nature of obstetric and gynaecological morbidities, quality of family planning services and the quality of maternal health services.

The project COMIRES (COmmunity Migrant RESearch) from the Department of Obstetrics and Gynecology at the University Hospitals of Geneva conducted a study to assess the lack of utilization of reproductive health services among the migrant communities. Community-Based Participatory Research (CBPR) was also done that focuses on inequalities of migrant women reproductive health. They revealed that these people are hesitant to adhere medical treatment instead opting for traditional medicine leading to further health hazards.

From the literature reviewed, the researcher identified that the prevalence of reproductive health problems were highly significant among migrant women inspite of various health services available. The researcher found that the migrant woman lacks

adequate health concern about their reproductive health problems because of their hesitancy and lack of awareness. This became the motivation for the researcher to assess the reproductive health status of migrant women and to explore the various precipitating factors for reproductive health problems to occur. Thereby, focusing on improving the migrant women's health so as to improve the women's health of the whole nation.

1.3STATEMENT OF THE PROBLEM

A descriptive study to assess the reproductive health problems among migrant women population at selected setting, Thiruvallur.

1.4 OBJECTIVES

1. To assess the reproductive health problems among migrant women population.
2. To identify the precipitating factors for reproductive health problems among migrant women population.

1.5 OPERATIONAL DEFINITIONS

1.5.1 Reproductive health problems

It refers to the changes in the reproductive health status of migrant women which includes reproductive tract infection, menstrual irregularities, anaemia, urinary incontinence and breast problems.

1.5.2 Migrant women population

It refers the gypsy women in the reproductive age group of 15-44 years who are residing in the temporary settlement areas in Thiruvallur District.

1.6 ASSUMPTION

Migrant women may have one or more reproductive health problems.

1.7 RESEARCH HYPOTHESIS

RH: There are significant precipitating factors for reproductive health problems of migrant women population at $p<0.05$.

1.8 DELIMITATION

The study was delimited to a period of 4 weeks.

1.9 CONCEPTUAL FRAMEWORK

A conceptual framework or model to interrelated concepts gathered together in a rational scheme by virtue of their relevance to a common theme that proposes a framework for conducting research.

The investigator adopted the conceptual framework based on **Betty Newman's System Model,** which was used to identify the precipitating factors for reproductive health problems. The dynamic interaction between person and their environment was clearly depicted in the model.

Basic Core Structure

Determines includes physiological, developmental, spiritual factors and socio cultural factors which are distinct to each individual were explained under the basic core structure. This component of the model also discusses the response to the stressors by the individual and aids them to cope up with these stressors.

The core structure of the model represents married migrant women who are having the reproductive health problems between the age group 15-44 years.

Stressor

Stressors are factors or a stimulus that disrupts or manipulate the body's equilibrium.

The migrant women may or may not be exposed dietary factors, menstrual factors, personal hygiene factors and sexual factors.

Line of resistance

Line of resistance is a broken line, which acts only when the normal line of defence could not cope up with the stressor leading to alteration in normal health pattern. The line of resistances helps to facilitate coping and overcome the stressors which affects the individual.

The line of resistance of this model indicates migrant women with all or some exhibiting certain precipitating factors for reproductive health problems.

Normal line of defence

It operates in consistence with a state of wellness. It is the response of woman when exposed to any stressors. The normal line of defence is considered as the essential element of health in the health continuum.

In this the migrant women normal line of defence is they seek health care support regularly through Primary health centre.

Flexible line of defence

Flexible line of defence involves the body's coping mechanism which helps to overcome the stressor/stressful situations thereby assist in achieving a state of equilibrium in the woman's system.

In this the migrant women is unable to manage the stressors and hence developed the reproductive health problems.

Degree of action

The end result of stressors and coping mechanism adopted by the line of resistance is termed as the degree of reaction. Depending on the woman's reaction towards and degree of reaction, the result may be positive or negative.

The migrant women exhibit the sign and symptoms for reproductive health problems which are assessed by using structured interview schedule.

Secondary prevention

Secondary prevention the investigators aim at eliminating the factors which have resulted in alteration health.

Identify the precipitating factors for reproductive health problems such as menstrual irregularity, reproductive tract infection, urinary incontinence, anaemia, breast problems.

Through this the investigator developed the assessment criteria for regular screening of reproductive health problems of migrant women. Screening of the migrant women by using the structures interview schedule. Migrant women who didn't have the reproductive health problems were reinforced towards maintenance of reproductive health through health education.

Tertiary prevention

Tertiary prevention focuses on rehabilitation, thus in strengthening woman's core structure after being exposed to stressors and experiencing ill effects of it. Its central purpose is to prevent reproductive health problems.

Migrant women who had reproductive health problems referred the women to tertiary care hospital.

It is therefore evident that this conceptual framework based on Betty Neuman's System model is appropriate for this study. The study provided to be perfect guidance for logical framework development of the study which enhanced the investigator to design the outline for the study by giving related phenomena and concepts for migrant women. It also helped the investigator to blend various components of the theory into different aspects of nursing practice throughout the study, thus enabling to identify the precipitating factors for reproductive health problems among migrant women

INVESTIGATOR

STRESSORS
- **Dietary factors**
- **Menstrual factors**
- **Personal hygiene factors**
- **Sexual factors**

LINE OF RESISTENCE
Exhibiting certain precipitating factors for reproductive health problems

SECONDARY PREVENTION
Identify the precipitating factors for Reproductive health problems such as
- Menstrual irregularity
- Reproductive tract infection
- Urinary incontinence
- Anemia
- Breast problems

Flexible of defence
Normal line of defence
Line of Resistence

BASIC CORE STRUCTURE
Health Status of migrant women

NORMAL LINE OF DEFENSE
Regular follow up through PHC

FLEXIBLE LINE OF DEFENCE
The migrant women's may or may not be able to adjust with stressors

Developing the assessment criteria for regular screening of reproductive health problems of migrant women

Screening of migrant women by using the structures interview schedule

Migrant women who had reproductive health problems

Migrant women who didn't have the reproductive health problems, were reinforced towards maintenance of reproductive of health through health education.

TERITARY PREVENTION
Referred the women to tertiary care hospital

DEGREE OF REACTION
Migrant women exhibits the sign and symptoms of reproductive health which is assessed by structured interview schedule.

CONTEXT:
Migrant Temporary settlement area, Pinjivakkam, Thiruvallur District.

Fig.1.9.1: CONCEPTUAL FRAMEWORK BASED ON BETTY NEWMAN'S SYSTEM MODEL

1.10 OUTLINE OF THE REPORT

Chapter 1: Deals with the background of the study, need for the study, statement of the problem, objectives, conceptual framework and delimitations.

Chapter 2: Contains review of literature

Chapter 3: Presents of methodology of the study and plan for data analysis

Chapter 4: Focuses on the data analysis and data interpretation

Chapter 5: Enumerates the discussion of the study

Chapter 6: Gives the summary, conclusions, implications, recommendations and limitations.

The study report ends with selected references and appendices.

CHAPTER – 2

REVIEW OF LITERATURE

REVIEW OF LITERATURE

This chapter focuses on literature review, which helps to lay the context and foundation for this study. Literature review refers to a "written summary of evidence on a research problem". Polit and Beck (2012).

Review of literature is a systematic and logical arrangement of information that is carefully selected from scientific writings. It is essential aspects of scientific research and entails the systematic identification, reflection, critical analysis and reporting of existing information in relation to the problem of interest.

The literature review was collected from various sources such as primary sources: from research reports, conferences manuals, and theses, secondary sources: reviews from the internet, national and international journal articles and tertiary sources from obstetrical and gynaecological nursing, community health nursing and medical books. The ultimate purpose of a good review of literature in this study is to obtain comprehensive knowledge and in-depth information about the reproductive health problems and various updated sources and organize them scientifically within the framework of current research project.

The review of literature was done using the keywords such as reproductive health, procreative health, risk factors, migrant women population, gypsy women, sexual health, prevalence of reproductive health problems, reproductive tract infection, anaemia, urinary incontinence, risk factors of breast problems etc. A systematic literature review of articles dating from 2010 to 2016 was incorporated from standard database such as Cochrane library, Cumulative Index to Nursing and Allied Health (CINHAL), Google scholar, Medical Literature Analysis and Retrieval (MEDLINE), PubMed and other unpublished studies from dissertations.

It includes qualitative studies, observational studies, experimental studies like true experimental (pre and post-test) quasi experimental,comparative studies, descriptive studies, prospective and retrospective studies.

Collectively 100 studies were searched out of which 65 relevant and updated studies were utilized to support the current topic. Among the selected and updated studies, 38 were international and 32 were Indian reviews which includes 31Nursing reviews.

ORGANIZATION OF REVIEW OF LITERATURE

For the purpose of logical and systematic sequence the chapter is divided into the following two sections:

SECTION 2.1: Critical reviews related to reproductive health problems among general women population.

SECTION 2.2: Critical reviews related to prevalence of reproductive health problems among migrant women population

SECTION 2.3: Critical and scientific reviews related to precipitating factors and prevention of reproductive health problems among general and migrant women population

SECTION 2.1: CRITICAL REVIEWS RELATED TO REPRODUCTIVE HEALTH PROBLEMS AMONG GENERAL WOMEN POPULATION.

A few researchers (John, Fibrose, Rajesh 2011; Prana, Arithiya and Hemilda 2011; Ancy, 2013)found in their cross sectional survey that higher parity women, lack of awareness, poor hygiene had led to problems such as anaemia, leucorrhoea, urinary problems and genital prolapse. In addition, all the above mentioned factors also resulted in postpartum haemorrhage, prolonged labour, obstructed labour, perineal tear and breast disorders. These studies identified two key factors low socio-economic status and lack of education as a cause for reproductive health problems namely anaemia and leucorrhoea. Several retrospective studies conducted by (Lale soy, 2011; Pallavi Lal, 2012; Royjohnson, Rohan, 2013) identified that gynaecological and psychosocial factors are strongly associated with chronic pelvic pain which greatly affects the reproductive health of females.

Indian Researchers (Sandhya .P, 2010; Sharddha.A, Bharti.B. M, Morgan; Ribbu 2011; Amrose et al, 2011) also have supplemented their findings to the above factors stating that low socio economic status along with the environmental conditions like slum will also influence reproductive health which is predominantly due to poor utilization of

the reproductive and child health services provided by the government, lack of awareness regarding birth spacing and very low use of contraceptives. Likewise, education regarding breast self-examination and proper follow up is necessary to prevent and also considered a early treatment for women in child bearing age who were prone to get fibroadenoma, fibroadenosis, breast abscess, sebaceous cyst, duct papilloma, lipoma and galactoceleetc.

A couple of researchers (Melani ,2010 ;Savitha B Guptha et al ,2011) reported that women in developing countries at reproductive age group are high risk of vaginal discharge, itching, genital ulcer disease, lower abdominal pain usually being treated freely in a PHC. In particularly, leucorrhoea and poor personal hygiene. Peters J,Cooper C(2012) conducted a comparative study found that the prevalence of vaginal discharge increased in rural then urban age group of women is 15-44years and had curdy discharge.

Most of the studies Ahmed M, Noor Mohamed, Bhaskarrao, (2011) Mukesh, Lalitha, (2012) reported that leucorrhoea common problem found in lower socioeconomic status and married with high parity at a very young age. By using a saline wet preparation, the results revealed that increased rates of test being positive for C.trachomatisand N.gonorrhoea, proving the presence of both bacterial vaginosis and leucorrhoea being associated with an increased risk of cervical infection. Ebseba, Rabega.K et al (2012) conducted a survey in three villages of Haryana and Panchkula for the prevalence of excessive vaginal discharge among married women due to heat, melting of bones, sexual promiscuity as the main health effects to weakness, backache, and poor vision. A cross sectional study was done by Shaokang Z, Anan S (2013)among 83,000 women with child bearing age in Boston, USA to assess the risk factors for leucorrhoea. The results showed that 17% of the sample reported to have leucorrhea, 25% of the total sample were identified to have sexually transmitted disease, 12% of the sample were suffering from bacterial infections. Interestingly, another finding of the study revealed that 50% of the sample were diagnosed to have anemia, 20% of the samples were in the menopausal period.

Numerous studies (Parashar, BP, 2010; Gupdha AK 2011; Bhardwaj, 2012) revealed that marriage and child bearing at a young age, high parity, poor access to medical facilities are considered to be the most important factors leading to high

prevalence rate in association to the life style of women in community. The results revealed that the common problems were cystocele, uterine prolapsed, rectocele, cervical erosion, inflammation, urinary incontinence and dyspareunia was found to be evident. Fredrick 2011; Wesley .l 2012; Kasthuri,2013)conducted a community based cross-sectional studies reporting that urinary incontinence prevalence was found significantly more in married females as compared to unmarried in reproductive age group women in an urban communities. Urinary incontinence was present more in married than in unmarried women, women of lower socioeconomic status and with high parity.

Researchers (Brunner, 2011; Clara, 2012) found that adolescents are vulnerable to reproductive health problems. The findings revealed that there is an increase in adolescent sexual activity, coupled with high rates of unplanned pregnancies, early childbearing and the transmission of sexually transmitted infections, including HIV.

Van Cleemput P, Parry G, et al (2011) conducted a cross sectional study regarding prevalence of RTIs and sexually Transmitted Diseases were more between the age group of 15-45 years. The study result showed that a total of 400women were interviewed and 235 of them were found to be suffering from RTIs giving a prevalence of 51.9%.The trend in relation to age showed maximum prevalence in the 25-34years which was statistically significant. The same cross-sectional study was done by Lazar B; Joseph; R, God fray;(2012) in Christian medial college to assess the women often suffer silently with reproductive tract infections which revealed that fifty-three percent of women reported gynecologic symptoms, 38% had laboratory findings of RTIs and 14% had clinically diagnosed pelvic inflammatory disease or cervicitis and they were from low social status especially young women, which indirectly has a significant influence on their low rates of treatment for these conditions.

Cambriya, Elegant Y, et al (2013) conducted an experimental study by assessing the prevalence of vulvovaginitis in order to take the appropriate therapeutic and preventive measures for leucorrhoea and vaginal diseases. By using a fresh wet mount examination, organgeacridine and giemsa stains for trichomonas and culture. Only in 57 women of total samples with vulvovaginitis, the causative agents were demonstrated. Candidiasis was present in 84.2% and T.vaginalis in 14% was detected, and symptoms

they had like vulvarpruritis and leucorrhoea was observed in significant number of patients with vulvo vaginal candidiasis.

A huge number of studies (Rubia A, Ambrose 2011; Sofia, 2012; S. Altuwaijri, 2012; Hentrypaul J Rimple, 2012; Abdul 2013) identified that pregnant women are at risk to develop vaginal candida infection during the third trimester due to a vaginal yeast colonization. The studies also revealed that for emergency purpose they were treated locally with antimycotic vaginal globules and crème for 5 to 7 days which alleviates the clinical symptoms.

Series of researchers (Victor R Thomas 2011, Meera 2012, Linsa 2012, Raimy Jacob, 2013) conducted a retrospective study and found that prevalence of anemia more common in adolescents than in pregnant women. Anemia was diagnosed by estimating the hemoglobin concentration in the blood, using indirect cyanmethemoglobin method. The survey data showed that nearly 85% of pregnant women and 90% of adolescent girls were mostly anemic. While, Finlay Jonah 2012, Martina, Masilamani, (2013) conducted descriptive studies that adolescents girls are vulnerable to anemia in rural area by using check list and hemoglobin estimation was done through cyanmethglobin method. The result shown that nearly half the population were having anemia.

N. Karout 2010; S.M. Hawai (2010) conducted a quasi-experimental study to determine the prevalence and pattern of menstrual symptoms among reproductive age women. The findings revealed that the most common menstrual disorders were irregular frequency of menstruation (80.7%), premenstrual syndrome (54.0%), irregular duration of menstruation (43.8%), dysmenorrhoea (38.1%), polymenorrhoea (37.5%) and oligomenorrhoea (19.3%).Similarly, a prospective study by (Mary Catherin .B, 2010; Kasthuri , et al ,2011; Karun T, Anil .E , et al ,2010 ;A , Kishore M , et,al 2012) showed that the adolescents girls are vulnerable to menstrual disorders especially, students with dysmenorrheal and oligomenorrhoea. Further Loreta,P, Rinu,et al (2013) identified that there is a rapid increase in the prevalence of other menstrual disorders like irregularity, prolonged menstrual bleeding, heavy menstrual bleeding and PCOD.

Series of researchers (Samuel Shapiro 2010; Arthur Schatzkin, Julie R. Palmer 2010; Lynnrosenberg 2011; Davidkaufman et al 2012;Lynn Rosenberg 2012; Helmrich

et,al 2013) conducted explorative studies to evaluate risk factors for breast cancer among women in various hospitals .The risk of breast cancer increased with increasing age at first birth and late age at menarche was associated with a risk among premenopausal women and postmenopausal women. Among premenopausal women, the risk was higher for those who were obese yet there was no evidence of a trend with increasing body mass index.

A chain of retrospective studies by (Italo G. Rimy Jose, et al 2009; Jay H. Lubin, Patricia E. Burns 2010, William J. Blot 2013) found that the risk of breast problems in breast cancer, the family history of breast cancer may raise colorectal cancer risk having a 1st relative with breast cancer may slightly risk. Moreover, The Indian Council of Medical Research exploited that the incidence of breast cancer is high among Indian females in the metropolitan cities and it is estimated that one in every 22 Indian female are at a risk to develop breast cancer during their lifetime. In addition, survey revealed that 60% of the patients belonged to the age group of 25-45 with Goa paying large account on urban lifestyle associated with high affluence and late marriages.

SECTION 2.2: CRITICAL REVIEW RELATED TO PREVALENCE OF REPRODUCTIVE HEALTH PROBLEMS AMONG MIGRANT WOMEN POPULATION

Van Cleemputp (2010); Parry G, (2012) conducted a descriptive studies whofound that migrant women vulnerable to develop a reproductive health problems in England rural community with their major problems being Leucorrhoea, menstrual irregularity, breast problems, and anemia. An identical study by Holy J, Rogers A, et al; (2012) explored in that prevalence of reproductive health problems among Ghumantoo nomadic tribes of Rajasthan state in India, to study the prevalence rate of various diseases. The study involved about 1286 participants. Information regarding various diseases among the study population was obtained through questionnaires. Results showed that the prevalence of anemia and Leucorrhoea were maximum among them.

Bandana Sachdev, et al (2014) observed that the perception regarding various reproductive health issues among the 1113 nomadic populations in select districts of Jhunjhunu, Rajasthan. The data was obtained through semi structured questionnaires .The findings reveals that the nomad tribal environment and sense of community with

which its associated strong social networks are identified as key determinants for common perception in all reproductive health issues, and they have recommended to increase the priorities for reproductive health care, greater effort and resources are required to increase their awareness and change the attitude towards reproductive health issues.

Danhualin, Xiaoyi Fang(2011), Mao Rong, Jingwang (2012) conducted a cross-sectional studies which reported that migrant population had significantly poorer health status than the general women and also the main factor is low socio economic status. According to King Wong, Fengna, Lonchang, (2012) in their descriptive study to know the attitudes among reproductive health problems among rural, China found that migrant women negatively adopt and non-migrant women positively adopt family planning and reproductive health attitudes and behaviour in their rural communities of origin.

Milsom I , Ekelund P (2010), Molander U (2011), Arvidsson L et al (2013) found in their descriptive studies the prevalence of urinary incontinence among reproductive age group migrant women influence the age, parity, oral contraception, hysterectomy and menopause on the prevalence of urinary incontinence in women, likewise that the normal delivery women had more incidence than caesarean section.

An Indian research by the Community Health Department (2011) conducted a survey regarding prevalence of reproductive health problems among migrant in Kerala, and they found prevalence of reproductive tract infection 49%, menstrual irregularity 36% and infertility 15%. Many researchers (Regina G. Zieglar,2010; Robert N. Hoover 2011; Malcolm C. Pike, 2011)conducted a retrospective studies to assess the risk of breast problems among migrant women. The study reported that result of the family history of breast cancer may raise breast problem in gypsy. A duo of researches (Morrone A 2010;Piombol L, Scardella P, et al, 2011) explored that the prevalence of anemia and the iron status of migrant women in Tamilnadu. The laboratory screening was done to 821 migrant women which concluded that 90% of migrant women had anemia.

SECTION 2.3: CRITICAL AND SCIENTIFIC REVIEWS RELATED TO PRECIPITATING FACTOR AND PREVENTION OF REPRODUCTIVE HEALTH PROBLEMS AMONG GENERAL AND MIGRANT WOMEN POPULATION

Lack of knowledge, attitude, and practices in reproductive health will lead to reproductive health issue among the adolescents, as identified by Kibert. Moessur, (2011) Health teaching programme was considered the only remedial action to alleviate the future problems and access to health services. The same was given due importance by Nicole M.; Bellows, Ben; W.Bellows; and Charlotte(2013) in a study conducted by them that the reproductive health programs will help to increase the health care utilization, improves the quality of care and reduces the reproductive health problems. The findings was also supported by Neelammann, Rajina, Renold, et al 2010; Francis, Obare 2012; who explored that education program will increase their knowledge and promote reproductive health including menstrual hygiene, personal hygiene etc especially among adolescent girls who are at higher risk of reproductive health problems. Alison M. Spitz et al, (2013) describes that increasing awareness inturn helps in preventing reproductive health problems can be achieved by regular screening and evaluation.

A handful of researches (Therese Hesketh 2010; Ye Xue Jun, et al 2010; Becker.H, Benye t.al, 2012; Charlotte Warren, Michel 2013) explored that adolescents girls are vulnerable risk to poor reproductive health due to lack of awareness about reproductive health due to low life skills. The problem reported mostly 95% being menstrual morbidity and others had symptoms suggestive of reproductive urinary tract infection. Adolescents girls need to initiate community-level life skill education, sex education and change the health behaviour. According to Brunner, clara,(2012),adolescents are vulnerable to reproductive health problems. The findings revealed that increase in adolescent sexual activity, coupled with high rates of unplanned pregnancies, early childbearing and the transmission of sexually transmitted infections, including HIV. So they need sex education, awareness about healthy life style. Nonetheless, Irwin.B, Kwis.l.r, Alwin (2011) department of Epidemiology, Institute of Basic Medical Sciences, Beijing proved that the influence of sociodemographic characteristics, knowledge, hygienic practices, attitudes, and behaviors related to premarital and extramarital sex, and abortion of RTI symptoms was high, indicating the

need for health education. The study identified that they had premarital sex, having sex during menstruation, belonging to an ethnic minority, among married women.

Certain studies (Thudy2012; Sunitha, Latha .A, et al 2013) assessed prevalence of menstrual disorders among adolescent girls in Singapore, due to increased BMI. 23.1% reported having irregular cycles. Oligomenorrhea was the most frequently reported problem (15.3%), and polymenorrhea was much less prevalent (2.0%). With increasing body mass index (BMI), there was a significant increase in the prevalence of oligomenorrhea, whereas polymenorrhea was more prevalent in the girls with a low BMI. Owing to it appropriate health education measures to be put into place to prevent this trend.

A multiple researchers (Sadhna Singh, 2012; Teresa Cue, et al 2011; Longchangxg, Kirbaann, et al 2012; Loreta ,P, Rinu, et al 2013) conducted descriptive studies to assess the reproductive health status and menstrual hygiene practices among married migrant women population Rajasthan and among adolescents in Rewa India respectively. They revealed that need to improve facilities due to lack of accessibility, affordability and acceptability and lack of knowledge among young migrants.

Wang Feng , Ping Ren, Zhan Shaokang and Shen Anan, (2013); Frank, Ghan, Vanghan, (2013) conducted a cross-sectional study to assess the reproductive health status, knowledge, and access to health care among female migrants in shanghai, china. Results of this study show a relatively low level of self-reported reproductive health problems among female migrants, coupled with a relatively high level of ignorance in knowledge related to STD. This study also finds ample evidence that female migrants, access to urban health care is limited by a number of institutional barriers to utilize health services.

Tamasbereczke Rim Dunbaret.al (2013) evaluated the knowledge and its association with the socioeconomic and demographic profile among 150 gypsy women of Jammu region. Most of them had lack of knowledge about the reproductive health problems and recommended that there is an urgent need to upgrade the reproductive health standard of women. Koumans, Emilia (2010) undertook a retrospective study to assess reproductive health and to provide an up to date report regarding the health status

among Roma in Europe as well as to highlight the best practices that should be adopted from health care services in order to eliminate the existing health inequalities that affect this vulnerable group. The findings reveals that great amount of studies and reports were retrieved focusing on Roma's health status, Health issues, reproductive and child health, vaccination, nutrition, lifestyle and access to health care were categorized so as to have an overall view of the health status of Roma. They have recommended that is a huge gap between the health status of Roma people and the rest of the population. Best practices, such as engagement of health mediators, integrated programs, co-operation of health and social workers and outreach services should be given emphasis.

Holy J Edward 2011;Rogers A, Wilson.D 2012; Nicolus.F 2012; Hentry, 2013 conducted a cross-sectional study prevalence of Leucorrhoea among nomadic tribes which showed that the lack of awareness and illiteracy will lead to the cause of these problems.Leo das, R,Reenujames L et al (2013) conducted a cross-sectional study to assess unhygienic environment of the gypsies coupled with sub-standard settlements bereft of basic amenities which greatly compromise the health and wellbeing of the gypsy dwellers especially women who residing in a sub-standard settlements in the city corporation of Chennai, Tamil Nadu. They are not only economically and socially backward but also a neglected and marginalized section of society. The study has revealed that poor health status among women was also due to marriages at an early age, resulting in early age pregnancies and improper pregnancy spacing .The study reveals that as women are less educated their awareness standard in these matters is also very low.

A community based survey (Bonita Stanton, Mayo Rong, 2012) conducted on menstrual hygiene practices and reproductive morbidity in rural women in Thiruvananthapuram, Kerala. The sample comprised 360 married or unmarried, non-pregnant, non-lactating women in the reproductive age group (12-45).Majority (60.8 percent, 95%CI: 56.4 -65.2)) dealt with menstruation unhygienically. A statistically significant association was seen between menstrual hygiene maintenance and education, SES, knowledge prior to menarche, type of protection, and accessibility to water, bathroom facilities and menstrual disorders. Finally concluded in the post test there was a need for health education.

Enormous researches (Ali, 1994; Basu, 1993, 1995; Chaudhuri, 1994; Chakravarty et al., 2005;l Mohindra, 2009; Mann, 1996; Sikdar, 2009;Mohindra et al., 2006; Mohindra and Haddad, 2005; Chakravarty et al., 2005) viewed that access to institutional support is an economic factor correlated to reproductive health. Several factors were reported as the social factor correlated to tribal women's reproductive health such as, marriage practice social status of women health and hygiene practice. Marriage Practice, the cultural norm of marriage practice has robust direct and indirect effect on reproductive health of tribal women. For instance, in tribal marriage, spouse is selected according to traditional custom which may directly influence the reproductive practice by deciding the partners in a sexual union. On the other hand, marriage practice indirectly influences the reproductive health of women by determining several other factors such as, age at marriage, pattern of family organization, women's status in society, and, women's decision making ability (Kshatriya, 1992). Each of tribal marriage practice may influence the reproductive health in distinct way; for instance, consanguineous marriage can lead to increased miscarriage, still births, neo-natal deaths, and physical and mental defects

Marriage practice also indicates whether a woman is in a polygamous or monogamous relationship. Several Himalayan tribes such as, Naga and Lusia practice polygamy, mainly for economic reason of having enough helping hands for agricultural activities. By 23 contrast, many tribes such as, Jausaris and Todas used to practice polyandry and there are many tribes who strictly practice monogamous marriage such as, Lodhas of West Bengal .Such marriage practice strongly shapes the family and social structure, division of labor within the group, women's status and decision making ability, and in turn influences the reproductive health of the women.

The age of Marriage Tribal women's age of marriage not always reflects their age at entry to sexual union, since unlike non-tribal Indian society, virginity is not crucially 'valued' by many tribal groups (Vidyarthi & Rai, 1977). However, age of marriage varies across the tribal groups in India. Tribal women's from north-eastern region of India enjoy higher age of marriage compare to the tribal in the central and south regions (Sinha, 1986). Marriage at delayed or matured age may attribute to higher level of economic and educational attainment by the women, which in turn can influence their reproductive health. Education Level of education and several indicators of reproductive health are strongly correlated such as contraceptive use (Martin, 1995; United Nations, 1987) and exposure to sexual intercourse.

(Cleland & Rodriguez, 1988; Cochran & Farid, 1989; Bawah, 2002; Sunil & Pillai, 2010;Sunil & Pillai, 2010), age at first menstruation and, decision making power of women particularly in the tribal context with limited healthcare resources, education of mother becomes very crucial which is a strong correlate of infant mortality. In general, literacy among the tribal is very low. Primary Census Abstract of India shows the notable difference in the female literacy rate between the tribal (14.50%), and non-tribal (39.29%) or general population in India in 1991 (Shankar & Thamilarsan, 2003). Moreover, level of education and literacy among tribal vary. Literacy level of women not only influence their reproductive performance, it also influences their income, and consequently other factors of reproductive health such as health seeking behavior, health and hygiene practice, and age at first marriage. Social System of Gender Hierarchy Unlike the mainstream Indian society, tribal women may enjoy the privilege of living in a matriarchal society.

A handful researches (Basu, 1995; Mann, 1996; Sikdar, 2009; Zaman, 2008) reveal that Tribal societies in India generally are patriarchal but there are few matrilineal tribal groups such as, Khasi, Garo, Jaintia, Lalung and Rabha of North Eastern India. The higher status of tribal women in matrilineal societies compared to that of women in patrilineal tribal societies. Even in patriarchal tribal societies, women enjoy relatively more freedom and higher status than the women in non-tribal societies. However, overall status of tribal men is higher than that of tribal women, and change in the status of women leading to inferior position in tribal societies has been underscored by scholars (Chauhan, 1990; Mann, 1996).

In such context, Mann, 1996 tells that tribal women's experience of living in a patriarchal or matriarchal society would determine whether or to what extent they have control over reproductive decision making, their earning, sexuality, and other reproductive behavior related to fertility. The Status of Women in a society is strongly influenced by the dominant social values and societal gender perspective. The traditional privileged position or status of tribal women within groups is going through change which is reflected in the shifting trend in Indian tribal societies from matrilineal system to the patrilineal system, and often from polyandry practice to monogamy practice.

(Das Gupta & Chen, 1996; Mohindra, 2009; Sunil & Pillai, 2010) comprehend that status of women also correlates to women's economic power, opportunity for education, access to community resources and networks, and most importantly

reproductive decision making power. All these successively can influence the reproductive health of tribal women. Religion and Caste System Hindu caste system marginalizes the tribal and limits their access to resources and networks in the mainstream society. Even though majority of the tribes in India are not Hindu by religion, reproductive health of tribal women are influenced due to social exclusion practiced by Hindu caste system. Such exclusion limits tribal opportunities in many areas such as, education, earning, and healthcare.

Chaudhuri, 1994; Khera, 1994).reports that reproductive health strongly correlates to health and hygiene practice of tribal population which is comprised of supernatural beliefs related to illness and treatment, strong role of traditional medicine men or shamans, community involvement in disease control and treatment, and mixed interventions of traditional and modern health care. Traditional tribal socio-religious practice also can adversely affect their women's reproductive health as well as tribe's general health, such as alcohol consumption during pregnancy. Health practice can impose taboo over crucial determinant of reproductive health such as food habit and diet. For instance, (Bhattacharya & Sengupta, 1986;Basu, Jindal, & Kshatriya, 1990) identified that Birhor tribe of West Bengal views food as 'agent' of inducing disease and restricts taking ingredients essential for nutrition, such as, salt taking is prohibited for women in postnatal period at least for three days after child birth.

Tribal women is central to the forest based economy where she plays a vital role in meeting basic necessities by collecting food, fuel, medicine, and housing material from the forest, and by participating in forest-dependent shifting cultivation and animal husbandry. Numerous studies (Dash & Pati, 2002; Menon, 1988; Basu, 1995; Rizvi, 1986; Gupta, Zafar, Mangal, & Sharma, 1983; Pati, 2002; Reddamma et al., 2002) identified that tribal women's diet is commonly deficient in calcium, vitamin A, riboflavin and animal protein. The most common disease that tribal women experience from malnutrition is anemia which can affect the reproductive health of women very adversely by lowering their resistance to fatigue and energy to work, and by increasing vulnerability to other diseases. The other reported prevalent diseases among tribal women are pyrexia, respiratory complaints, gastro-intestinal diseases and rheumatic diseases, and gynecological problem (Basu, 1995; Gopalan, 1987). In many tribes, women do not take special or extra food while continuing their hard labor during pregnancy resulting in reduced body weight and hemoglobin of pregnant mothers leading to maternal mortality.

SUMMARY

The above literature provided scientific evidence to assess the reproductive health problems and its precipitating factors among migrant women and also stated the importance of secondary prevention.

During review of literature the investigator felt difficulty in gathering Indian literature and recent nursing reviews pertaining to the topic reproductive health problems among migrant women.

CHAPTER – 3

RESEARCH METHODOLOGY

RESEARCH METHODOLOGY

This chapter describes the methodology adopted in his study to assess the Reproductive health problems among migrant women population in selected settings at Thiruvallur, district, Tamilnadu.

This phase of the study included research design, variables, setting of the study, population, sample, criteria for sample selection, sample size, sampling technique, development and description of the tool, content validity, pilot study, and reliability of the tool, procedure for data collection and plan for data analysis.

3.1 RESEARCH APPROACH

The research approach used by the investigator was quantitative research approach.

3.2 RESEARCH DESIGN

The design used in the study was non experimental descriptive research design. The aim of the study was to assess the Reproductive health problems among migrant women population.

3.3 VARIABLES

3.3.1 Research variables

The research variables in the study were reproductive health problems such as menstrual irregularities, reproductive tract infection, urinary incontinence, anaemia, and breast problems.

3.3.2 Extraneous variables

The extraneous variables were type of family, education, diet pattern, age at marriage, duration of marital status and age at first child birth.

3.4 SETTING OF THE STUDY

The study was conducted at migrant temporary settlement area at Pinjivakkam, Thiruvallur district it covers about 500 migrant populations out of which 232 migrant

women with in the age group of 15-44 years. They are residing in their own house with common public toilet facility for both bathing and toileting. Majority of the women get self employed by selling the beaded ornaments.

3.5 POPULATION

3.5.1 Target population

All migrant women in the reproductive age of 15- 44 years.

3.5.2 Accessible population

All migrant women population who are residing in migrant temporary settlement areas of Pinjivakkam, Thiruvallur district.

3.6 SAMPLE

Migrant women who fulfilled the inclusion criteria were selected as samples for the study.

3.7 SAMPLE SIZE

Sample size comprised of 100 migrant women who fulfilled the inclusion criteria.

3.8 CRITERIA FOR SAMPLE SELECTION

3.8.1 Inclusion criteria

Migrant women who

1. were married
2. were willing to participate in the study.
3. could understand Tamil

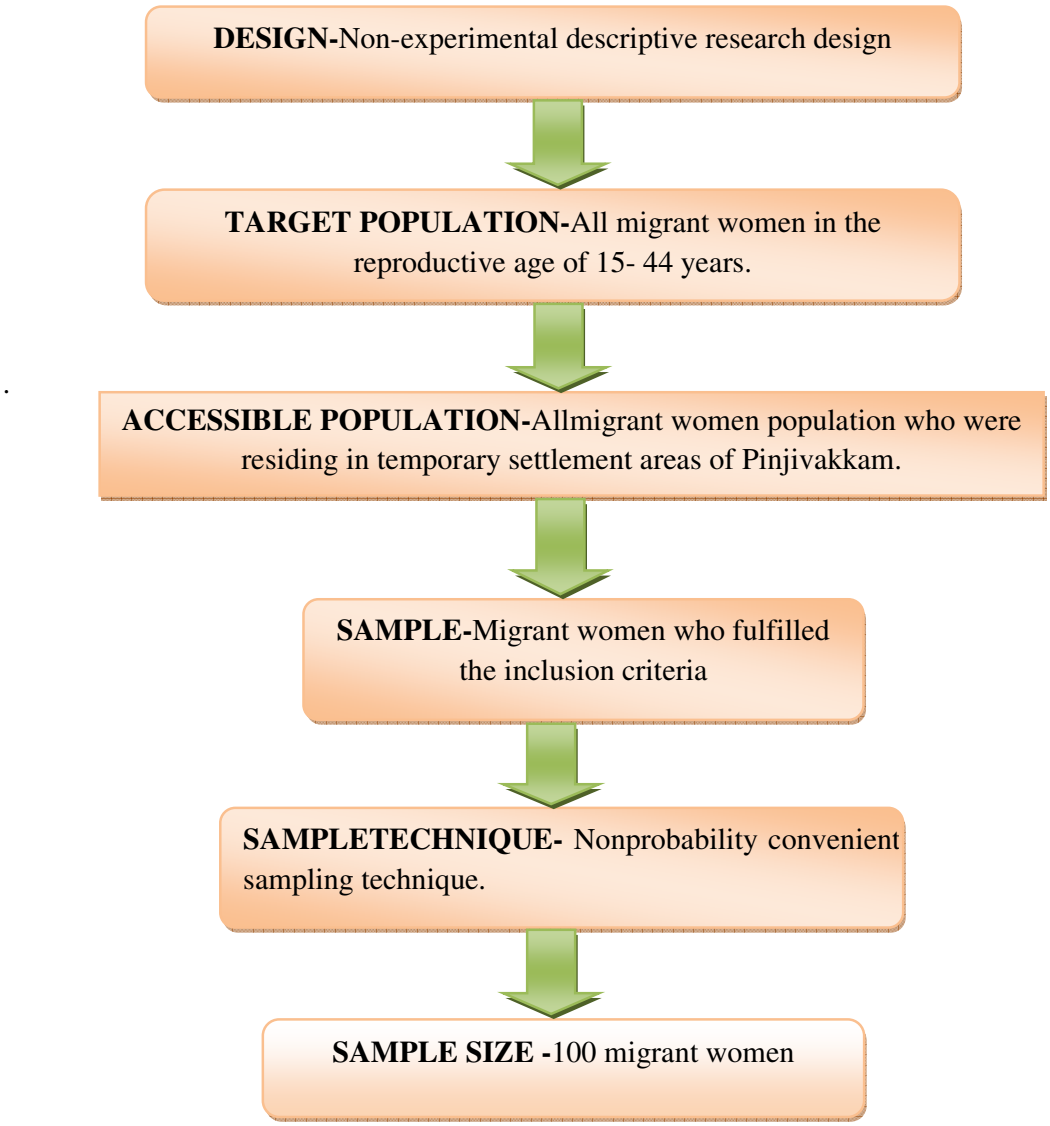
3.8.2 Exclusion criteria

Migrant women who was on treatment for reproductive health problems.

3.9 SAMPLING TECHNIQUE

Non-probability convenient sampling technique was used to select the samples.

Fig 3.5.1 SCHEMATIC REPRESENTATION OF SAMPLING



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3.10 DEVELOPMENT AND DESCRIPTION OF TOOL

After an extensive review of the literature, discussion with the experts and with the investigator's personal and professional experience, a structured interview schedule was developed to assess the reproductive health problems among migrant women population in the migrant temporary settlement area.

The tool constructed in the study was divided into two parts.

3.10.1 DATA COLLECTION TOOL

It consisted of 2 sections

Section A: Demographic data

Consisted of demographic variables which included age, education, occupation, monthly family income, type of family, religion, parity, and diet pattern. It also included study variables such as menstrual history, marital status, sexual history, contraceptive usage, and history of abortion.

Section B: Structured Interview Schedule

A structured interview schedule was developed to assess the reproductive health problems of migrant women. It comprised of 32 questions, out of which the first 6 are about menstrual irregularities, questions from 7-17 are about reproductive tract infection, the next two are about urinary incontinence, those from 21-32 are about anaemia and the remaining 33-45 questions are about breast problems.

3.11 CONTENT VALIDITY

The content validity of the data collection tool was ascertained from the experts' opinion in the following field of expertise.

- Obstetrician and Gynaecologist - 2
- Nursing experts -3

Modifications were made as per the expert suggestion and incorporated in the tool. Most of them suggested that few demographic variables to be changed in to clinical variables.

3.12 ETHICAL CONSIDERATION

The research study was approved by **Institutional Ethics Review Board (IERB)**, held December 2014 by International Centre for collaborative **Research (ICCR),** Omayal Achi College of Nursing.

The ethical principles followed in the study were,

A. BENEFICENCE

The investigator followed the fundamental ethical principle of beneficence by adhering to

a. The Right to freedom from harm and discomfort

Migrant women were not subjected to unnecessary risk from harm and discomfort during the study period. They were given full freedom to disclose their view in case if they feel any harm/discomfort.

b. The Right to Protection from exploitation

The investigator explained the procedure and nature of the study to the migrant women and ensured that none of the participants would be exploited in any cost or denied from fair treatment.

A. RESPECT FOR HUMAN DIGNITY

The investigator explained the second ethical principle of respect for human dignity. It includes the right to self-determination and the right to self- disclosure.

a. The Right to self determination

The researcher gave full freedom to the migrant women to decide voluntarily whether to participate in the study or to withdraw from the study and the right to ask questions during study.

b. The Right to full disclosure

The researcher has fully described the nature of the study, the person's right to refuse participation and the researcher's responsibilities based on which both oral and written informed consent was obtained from the participants.

C. JUSTICE

The researcher adhered to the third ethical principle of justice; it includes participant's right to fair treatment and right to privacy.

a. Right to fair treatment

The researcher selected the migrant women based on the research requirements, no vulnerable or compromised candidates were selected as study samples.

b. Right to privacy

The investigator maintained the participant's privacy by performing assessment in the private room. Confidentiality pledge obtained by informed written consent from migrant population.

D. CONFIDENTIALITY

The researcher maintained confidentiality of the data provided by the migrant women.

3.13 RELIABILITY OF THE TOOL

The reliability of the tool was established by interrater method with "r'" value of 0.8. It was found that the tool was reliable and practicable to implement in the main study.

3.14 PILOT STUDY

The pilot study is a trial run for the main study; the refined tool was used for pilot study to test feasibility and practicability. After getting ethical committee clearance from ICCR, formal permission from Prinicipal, Omayal Achi College of Nursing, and Ward member of the Thiruvallur Panchayat. The Pilot study was conducted in the month of November 22/11/2015 to 1/12/2015, at migrant temporary settlement area, under the flyover, Thiruvallur. The investigator conducted the pilot study by selecting 25 migrant women, who fulfilled the sample selection criteria by non-probability convenient sampling technique.

The investigator gave a brief introduction about self and purpose of the study to the migrant women. The researcher assured the participant's regarding the confidentiality of their information. After obtaining the verbal and written informed consent for willingness to participate in the study, structured interview schedule was used to assess the reproductive health problems. The investigator spent 20 to 30 minutes for each participant to collect the data.

The analysis of the data and the result of pilot study gave the evidence that the tool were feasible and practicable to implement the main study.

3.15 PROCEDURE FOR DATA COLLECTION

The investigator obtained formal permission from the International Centre for Collaborative Research (ICCR) and ethical clearance to precede with the main study. A formal permission was obtained from the Principal, Omayal College of Nursing, and from the ward member of Athigathur panchayat, Thiruvallur district.

The study was conducted for a period of 4 weeks. The investigator conducted the study by selecting 100 samples, who fulfilled the sample selection criteria by using non-probability convenient sampling technique. After selecting the samples, the investigator gave brief introduction about self and purpose of the study to the participant. They were made to sit comfortably in a well ventilated room and assured the confidentiality regarding the data to win their cooperation during the data collection procedure. Verbal and written informed consent was obtained after clear explanation about the study. The investigator used structured interview schedule to assess the reproductive health problems, each sample took about 15 to 20 minutes to complete it. After the data collection, reproductive health problems and its prevention was explained through power point presentation.

3.16 PLAN FOR DATA ANALYSIS

Data collected was analysed by using both descriptive and inferential statistics.

3.16.1 Descriptive Statistics

Frequency and percentage distribution was used to analyse the demographic variables of migrant women.

3.16.2 Inferential Statistics

Binary logistic regression analysis odds ratio was used to identify the precipitating factors for reproductive health problems among migrant women.

CHAPTER – 4

DATA ANALYSIS AND INTERPRETATION

DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of the data collected from 100 samples to assess of reproductive health problems among migrant women. The collected was organized, tabulated and analyzed according to the objective. The findings based on the descriptive and inferential statistical are presented under the following.

ORGANIZATION OF THE DATA

Section 4.1: Description of selected demographic variables among migrant women population.

Section 4.2: Assessment of reproductive health problems among migrant women population.

Section 4.3: To identify the precipitating factors for reproductive health problems among migrant women population.

SECTION 4.1: DESCRIPTION OF DEMOGRAPHIC VARIABLES OF THE MIGRANT WOMEN.

Table 4.1.1: Frequency and percentage distribution of the demographic variables of migrant women with respect to age, education, and occupation

N=100

S. No.	Demographic Variables	No (%)
	Age in years	
1.	15 -19	6
	20 -24	12
	25 -29	25
	30 -34	**29**
	35 -39	18
	40 -44	10
2	**Education**	
	Non-literate	**96**
	Primary school	4
3	**Occupation**	
	Unemployed	22
	Skilled worker	**78**
4	**Family monthly income**	
	Rs 1803 – 5386	**86**
	Rs 5387 – 8988	14
5	**Type of family**	
	Nuclear family	**81**
	Joint family	19
6	**Religion**	
	Hindu	**69**
	Christian	31
7	**Diet Pattern**	
	Non-Vegetarian	**100**

The above table 4.1.1 depicts that most of the women were between the age group of 30-34years, Non-literates, majority of them were skilled workers and getting monthly income of Rs1803-5386 and they were from nuclear family and belonged to Hindu religion.

Table 4.1.2: Frequency and percentage distribution of the demographic variables of migrant women with respect to Gravida, Parity, Live birth, abortion.

N=100

S. No.	Demographic Variables	No (%)
	Gravida	
a)	G1 -G2	34
	G3 -G4	**57**
	G5 -G6	5
	G7 -G8	-
	NIL	4
b)	**Para**	
	P1 -P2	30
	P3 -P4	**43**
	P5 -P6	-
	P7 -P8	-
	Nil	27
c)	**live birth**	
	L1 -L2	30
	L3 -L4	**43**
	L5 -L6	-
	L7 -L8	-
	NIL	27
d)	**Abortion**	
	A1 -A2	**39**
	A3 -A4	-
	Nil	61
e)	**Type of abortion**	
	Legal	**36**
	Legal	3
	NA	61

The above table 4.1.2 depicts that majority of the women had conceived 3-4 times and they underwent 3-4 deliveries, currently having 3-4 children and with the history of 1-2 episodes of legal abortion.

Table 4.1.3: Frequency and percentage distribution of the study variables of migrant women with respect menstrual hygiene

N=100

S.No.	Study Variables	No (%)
8	**Duration of Menstruation**	
	3 -5 days	**62**
	6 -7 days	30
	8 -9 days	7
	10 -11 days	1
9	**Type of napkins**	
	Sanitary napkins	27
	Waste cloths	**73**
10	**Change of pad**	
	Once a day	25
	Twice a day	**67**
	Thrice a day	8

The above table 4.1.3 depicts that majority of the women had their menstruation for 3-5days; the type of napkin they used were waste cloths and they used to change it twice a day.

Table 4.1.4: Frequency and percentage distribution of the study variables of migrant women with marital history, sexual history, contraceptive history

N=100

S.No.	Study Variables	No (%)
11	**Marital status**	
	Living with spouse	**86**
	Separated	14
12	**Age at marriage**	
	15 -17 years	**87**
	18 -20years	13
13	**Duration of marriage**	
	< 5 years	10
	6 -10 years	19
	11 -15 years	**31**
	16 -20 years	29
	> 20 years	11
14	**Age at first child birth**	
	15-17 years	**75**
	18-21 years	25
15	**Frequency of coitus**	
	Once a while	**60**
	Weekly once	16
	Two times a week	6
	3-4 times a week	3
	>5 times per week	
16	**Contraceptive measures**	
	Yes	**62**
	No	38
17	**Yes means**	
	Permanent method	**32**
	Temporary method	30
	NA	38

The above table 4.1.4 shows that almost all the women were married and living with spouse, age of marriage was 15-17 years, and the duration of married life was between 11-15 years. Majority of them delivered their first child between 15-17 years. Most of the women had frequency of coitus once in a while and they underwent permanent sterilization.

SECTION 4.2: REPRODUCTIVE HEALTH PROBLEMS AMONG MIGRANT WOMEN.

Table 4.2.1: Frequency and percentage distribution of the study variables of migrant women with respect menstrual irregularity.

N=100

S. No.	Study Variables	No (%)
1	**Age at menarche**	
	10 -13 years	**82**
	14 -16 years	18
2	**Menstrual cycle**	
	Regular	48
	Irregular	**52**
3	**If Regular**	
	25 days once	10
	28 - 30 days once	**31**
	31 - 35 days once	6
	36 - 40 days once	1
	NA	52
4	**If Irregular**	
	Light or infrequent menstrual bleeding	14
	Painful menstruation	**20**
	Abnormal heavy bleeding	18
	NA	48
5	**Cultural health practices**	
	Yes	**45**
	No	55
6	**if yes**	
	Bland diet	**36**
	Avoid Non-veg	7
	NA	57

The above table 4.2.1 depicts that majority of the women attained menarche between 10-13 years, with the history of irregular menstrual cycle and most of them experienced painful menstruation and followed bland diet as a cultural practice for relieving pain.

Table 4.2.2: Frequency and percentage distribution of migrant women with reproductive tract infection.

N=100

S.No.	Reproductive Tract Infection	No (%)
1	**Frequent raise of temperature**	
	Yes	**29**
	No	71
2	**Back pain**	
	Yes	**53**
	No	47
3	**History of white discharge**	
	Yes	**54**
	No	**46**
4	**Odour**	
	Foul smell	15
	Fishy smell	**25**
	Pungent smell	5
	No odour	9
	NA	46
5	**Colour and consistency**	
	Clear with watery	17
	Creamy white and sticky	**19**
	Whitish with yellow	8
	Yellow creamy white and thick	10
	NA	46
6	**Frequency of white discharge**	
	5 days after menstrual period	1
	NA	46
7	**Itching**	
	Yes	**51**
	No	49
8	**If yes means**	
	Desire to scratch the skin slightly	16
	Scratches the skin often, redness and pricking sensation	**21**
	Strong desire to scratch the skin, swelling and burning sensation	14
	NA	49

The above table 4.2.2 illustrates that few women had frequent rise of temperature, many of them experienced back pain accompanied by white discharge which was creamy white and sticky in consistency with fishy smell and it occurred during the mid-menstrual cycle with desire to scratches the skin often.

Table 4.2.2(a): Frequency and percentage distribution of migrant women with reproductive tract infection and Urinary incontinence.

N=100

S.No.	Reproductive Tract Infections	No (%)
9	**Problems in the perineal area**	
	Genital lesion	-
	Genital injuries	-
	Genital warts	-
	NA	100
10	**Cultural health practices**	
	Yes	**55**
	No	45
11	**If yes**	
	White hibiscus flower	**52**
	Fenugreek seeds	3
	NA	45
12	**Incontinence of urine**	
	Yes	**56**
	No	44
13	**If yes**	
	Coughing	17
	Sneezing	**25**
	Physical activity - Mild activity	10
	Strenuous activity	3
	NA	45

The above table 4.2.2(a) illustrates that many women used white hibiscus flower as a cultural practice to reduce white discharge. In consideration to urinary incontinence, majority of them had drippling of urine during sneezing.

Table 4.2.3: Frequency and percentage distribution of migrant women with anemia

N=100

S.No.	Anemia	No (%)
1	**Feeling of tiredness**	
	Yes	**83**
	No	17
2	**Shortness of breath**	
	Yes	**31**
	No	69
3	**Palpitation**	
	Yes	**24**
	No	76
4	**Leg swelling**	
	Yes	**22**
	No	78
5	**If yes**	
	Grade I	**23**
	NA	77
6	**Colour of conjunctiva**	
	Pink in colour	11
	Pale in colour	89
7	**Colour of finger nail**	
	Pink in colour	**6**
	Pale in colour	94

The table 4.2.3 depicts that most of the migrant women had tiredness, pale conjunctiva and pale finger nail whereas few women had shortness of breath, palpitation, and grade I leg swelling.

Table 4.2.3(a): Frequency and percentage distribution of migrant women with anemia

N=100

S.No.	Anemia	No (%)
8	**Shape of the nail**	
	Spoon	24
	Clubbing	1
	Brittle nails	**31**
	NA	**44**
9	**Cultural health practices**	6
	Yes	**44**
	No	**56**
10	**If yes**	
	Having green leafy vegetables	**36**
	Jaggery	**7**
	NA	57
11	Are you taking dewarming tablets every six month once	
	No	100

The table 4.2.3(a) depicts that most of the women had brittle nails and they had the practice of taking green leafy vegetables for anemia, none of them had the habit of taking dewarming tablets every six months.

Table 4.2.4: Frequency and percentage distribution of migrant women with Breast problems

N=100

S. No.	Breast problems	N (%)
1	**Having breast problems**	
	Yes	**43**
	No	57
2	**A lump**	
	Yes	**19**
	No	81
3	**Swelling**	
	Yes	**12**
	No	88
4	**Pain**	
	Yes	**17**
	No	83
5	**Dimpling and Nipple retraction**	
	Yes	**5**
	No	95

The table 4.2.4 depicts that nearly 43% of women had breast problem, in that few had lump, pain and swelling in the breast, very few women had dimpling and nipple retraction.

Table 4.2.4(a): Frequency and percentage distribution of migrant women with Breast problems

N=100

S. No.	Breast problems	No (%)
6	**Redness of the nipple**	
	Yes	**4**
	No	96
7	**Scaly nipple**	
	Yes	**2**
	No	98
8	**Skin irritation**	
	Yes	**5**
	No	95
9	**Nipple discharge**	
	No	**100**
10	**Family history of breast problem**	
	Yes	**5**
	No	95
11	**If yes Specify**	
	Mastalgia	**2**
	Lump	2
	Breast cancer	1
	NA	95

The table 4.2.4(a) depicts that majority of the women had no redness of nipple, scaly nipple, skin irritation and nipple discharge, whereas very few women had family history of breast problem such as mastalgia.

SECTION 4.3: PRECIPITATING FACTORS FOR REPRODUCTIVE HEALTH PROBLEMS AMONG MIGRANT WOMEN.

Table 4.3.1(a): Binomial Logistic regression scores of demographic variables of migrant women having menstrual irregularities.

N=100

Demographic variables	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Age (15 -19 years) - (Ref)	.001			
Age (20 -24 years)	.999	0.00	0.00	.
Age (25 -29 years)	.377	0.19	0.24	41.95
Age (30 -34 years)	**.014****	**25.75**	**1.95**	**344.69**
Age (35 -39 years)	**.005****	**57.28**	**3.46**	**955.16**
Age (40 -44 years)	**.011****	**51.78**	**2.55**	**1069.47**
Education(Non Literate) – (Ref)				
Education(Primary school)	1.00	5.19	0.00	.
Occupation(Skilled worker) – (Ref)				
Occupation(Skilled worker)	.908	0.95	0.24	3.47
Family monthly income(Rs 1803 - 5386) – (Ref)				
Family monthly income(Rs 5387 – 8988)	.188	0.34	0.06	1.69
Type of family(Nuclear family) – (Ref)				
Type of family(Joint family)	.104	3.54	0.77	16.30
Religion(Hindu) – (Ref)				
Religion(Christian)	**.057***	**3.35**	**0.96**	**11.36**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The table 4.3.1(a) describes that the odds ratio of the women between 30-34years, 35-39years and 40-44 years had high statistical significance for having menstrual irregularity with reference to women between 15-19 years and odds of women who were Christian had statistical significance for having menstrual irregularity compared with Hindu women.

Table 4.3.1(b): Binomial Logistic regression scores of demographic variables of migrant women having Reproductive tract infection.

N=100

Demographic variables	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age (15 -19 years) - (Ref)	.380			
Age (20 -24 years)	.414	0.38	0.03	3.85
Age (25 -29 years)	.979	0.97	0.12	7.45
Age (30 -34 years)	.457	**2.15**	0.28	16.28
Age (35 -39 years)	.874	**1.18**	0.14	9.55
Age (40 -44 years)	.533	**2.08**	0.20	21.08
Education(Non Literate) – (Ref)				
Education(Primary school)	1.000	0.00	0.00	.
Occupation(Skilled worker) – (Ref)				
Occupation(Skilled worker)	.329	0.55	0.16	1.86
Family monthly income(Rs 1803 - 5386) – (Ref)				
Family monthly income(Rs 5387 – 8988)	**.090**	**3.68**	**0.89**	**15.98**
Type of family (Nuclear family) – (Ref)				
Type of family (Joint family)	.154	0.41	0.12	1.39
Religion (Hindu) – (Ref)				
Religion (Christian)	**.026***	**0.37**	**0.19**	**0.87**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The analysistable4.3.1.(b) shows that none of the above variable had statistical significance for having reproductive tract infection but the odds were high for having reproductive tract infection for women between 25-29years , 35-39 years and 40- 44 years with reference to women between 15-19 years of age. Odds for family income Rs.5387-8988 was high in comparison with family income 1803-5386 and odds of women who were Christian was statistically significant for having reproductive tract infection compared to Hindu women.

Table 4.3.1(c): Binomial Logistic regression scores of demographic variables of migrant women having Urinary incontinence.

N=100

Demographic variables	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age (15 -19 years) - (Ref)	.117			
Age (20 -24 years)	.416	2.85	0.22	35.69
Age (25 -29 years)	.234	4.08	0.40	41.50
Age (30 -34 years)	**.050***	**10.19**	**1.00**	**102.34**
Age (35 -39 years)	.117	6.63	0.62	70.67
Age (40 -44 years)	**.028***	**19.85**	**1.38**	**285.47**
Education(Non Literate) – (Ref)				
Education(Primary school)	1.000	0.00	0.00	.
Occupation(Skilled worker) – (Ref)				
Occupation(Skilled worker)	.759	1.18	0.39	3.55
Family monthly income (Rs 1803 - 5386) – (Ref)				
Family monthly income (Rs 5387 – 8988)	.456	1.67	0.48	5.98
Type of family (Nuclear family) – (Ref)				
Type of family (Joint family)	.644	0.78	0.25	2.35
Religion(Hindu) – (Ref)				
Religion(Christian)	.595	1.28	0.50	3.25

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The analysis in the table 4.3.1(c) shows that the odds of the women between 30-34 years and 40-44 years of age having statistically significant odds for having urinary incontinence with reference of women between 15-19 years. None of the other demographic variables had high.

Table 4.3.1(d): Binomial Logistic regression scores of demographic variables of migrant women having Anemia

N=100

Demographic variables	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age (15 -19 years)	.999	0.00	0.00	
Age (20 -24 years)	.606	0.54	0.05	5.59
Age (25 -29 years)	**.333**	**2.99**	**0.36**	**27.44**
Age (30 -34 years)	**.120**	**7.87**	**0.58**	**105.95**
Age (35 -39 years)	.998	0.00	0.00	-
Age (40 -44 years) - (Ref)	**-**	**-**	**-**	**-**
Education(Non Literate)	1.000	0.49	0.00	
Education(Primary school) – (Ref)	**-**	**-**	**-**	**-**
Occupation(Skilled worker)	.955	1.07	0.08	14.02
Occupation(Skilled worker) – (Ref)	**-**	**-**	**-**	**-**
Family income (Rs 1803 - 5386)	.998	0.00	0.00	
Family income(Rs 5387 – 8988) – (Ref)	**-**	**-**	**-**	**-**
Type of family(Nuclear family)	.647	1.65	0.19	14.09
Type of family(Joint family) – (Ref)	**-**	**-**	**-**	**-**
Religion(Hindu)	**.359**	**2.39**	**0.37**	**14.96**
Religion(Christian) – (Ref)	**-**	**-**	**-**	**-**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The above mentioned table 4.3.1(d) shows that none of the variable had statistically significance odds for having anemia, but the odds were high for the age (25-29) years and age (30-34) years for having anemia in comparison with age (15-19)years. Women who were Hindus had high odds for having anemia in comparison with Christian's women.

Table 4.3.1(e): Binomial Logistic regression scores of demographic variables of migrant women having Breast problems

N=100

Demographic variables	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age (15 -19 years)	.475	0.38	0.02	5.17
Age (20 -24 years)	.608	1.63	0.25	10.69
Age (25 -29 years)	.255	**2.54**	**0.52**	**12.45**
Age (30 -34 years)	.777	1.25	0.25	6.12
Age (35 -39 years)	.312	**2.37**	**0.45**	**12.68**
Age (40 -44 years) - (Ref)	-	-	-	-
Education(Non Literate)	1.000	0.00	0.00	
Education(Primary school) – (Ref)	-	-	-	-
Occupation(Skilled worker)	.152	**2.26**	**0.74**	**6.73**
Occupation(Skilled worker) – (Ref)	-	-	-	-
Family income (Rs 1803 - 5386)	.362	1.88	0.49	6.90
Family income (Rs 5387 – 8988) – (Ref)	-	-	-	-
Type of family(Nuclear family)	.885	1.85	0.35	3.28
Type of family(Joint family) – (Ref)	-	-	-	-
Religion(Hindu)	.701	0.86	0.33	2.08
Religion(Christian) – (Ref)	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The above mentioned table 4.3.1(e) describes that none of the variable had statistical significance odds for having breast problems, but the odds were high for women between age (25-29) years and (35-39) years for having breast problem in comparison with women between 15-19 years of age . Women who were skilled worker had high odds for having breast problems in comparison with unskilled worker.

Table 4.3.2(a): Binomial Logistic regression scores of menstrual history of migrant women having menstrual irregularities.

N=100

Menstrual history	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age at menarche (10 -13 years) – Ref	-	-	-	-
Age at menarche (14 -16 years)	.828	1.21	0.29	7.25
If Regular (25 days once) – Ref	-	-	-	-
If Regular (28 - 30 days once)	.943	0.91	0.08	10.13
If Regular (31 - 35 days once)	.867	1.31	0.05	32.15
If Regular (36 - 40 days once)	1.000	0.00	0.00	.
If Regular (Not Applicable)	-	-	-	-
If Irregular (Light or infrequent menstrual bleeding) – Ref	-	-	-	-
If Irregular (Painful menstruation)	.653	**1.66**	**0.19**	**13.56**
If Irregular (Abnormal heavy bleeding)	.942	0.92	0.11	7.22
If Irregular (Not Applicable) – Ref	-	-	-	-
Cultural health practices (Yes)	.754	1.39	0.17	11.21
Cultural health practices (No) – Ref	-	-	-	-
if yes (Bland diet)	.621	0.64	0.11	3.74
if yes (Avoid Non-veg)	.797	1.48	0.91	22.82
if yes (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

The above table 4.3.2(a) shows that none of the variable had statistically significance odds for having menstrual irregularity women with painful menstruation had high odds for having menstrual irregularity in comparison in women who had light or infrequent menstrual bleeding.

Table 4.3.2(b): Binomial Logistic regression scores of menstrual history of migrant women having reproductive tract infection

N=100

Menstrual history	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age at menarche (10 -13 years) – Ref	-	-	-	-
Age at menarche (14 -16 years)	.291	**1.99**	**0.55**	**7.16**
Menstrual cycle (Regular) – Ref	-	-	-	-
Menstrual cycle (Irregular)	.727	0.71	0.10	4.77
If Regular (25 days once) – Ref	-	-	-	-
If Regular (28 - 30 days once)	.852	0.86	0.19	3.82
If Regular (31 - 35 days once)	.175	0.19	0.01	2.05
If Regular (36 - 40 days once)	1.000	0.00	0.00	.
If Regular (Not Applicable)	-	-	-	-
If Irregular (Light or infrequent menstrual bleeding) – Ref	-	-	-	-
If Irregular (Painful menstruation)	.818	1.19	0.26	5.28
If Irregular (Abnormal heavy bleeding)	.907	0.91	0.19	4.29
If Irregular (Not Applicable) – Ref	-	-	-	-
Cultural health practices (Yes)	.505	1.63	0.38	7.00
Cultural health practices (No) – Ref	-	-	-	-
if yes (Bland diet)	.860	1.10	0.35	3.45
if yes (Avoid Non-veg)	.305	**2.91**	**0.37**	**22.44**
if yes (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.2(b) shows that none of the variable had statistically significant odds for having reproductive tract infection , but the odds were high for women between age (14-16) years for having reproductive tract infection in comparison with women between (10-13) years of age . Women with cultural health practices such as avoiding non-vegetarian foods had high odds for having reproductive tract infection in comparison with women not having any cultural practices.

Table 4.3.2(c): Binomial Logistic regression scores of menstrual history of migrant women having urinary incontinence

N= 100

Menstrual history	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Age at menarche (10 -13 years) – Ref	-	-	-	-
Age at menarche (14 -16 years)	.865	1.10	0.34	3.50
Menstrual cycle (Regular) – Ref	-	-	-	-
Menstrual cycle (Irregular)	.218	0.30	0.04	2.00
If Regular (25 days once) – Ref	-	-	-	-
If Regular (28 - 30 days once)	.780	0.81	0.18	3.50
If Regular (31 - 35 days once)	.881	1.18	0.13	10.64
If Regular (36 - 40 days once)	1.000	0.00	0.00	.
If Regular (Not Applicable)	-	-	-	-
If Irregular (Light or infrequent menstrual bleeding) – Ref	-	-	-	-
If Irregular (Painful menstruation)	0.392	**1.85**	**0.45**	**7.63**
If Irregular (Abnormal heavy bleeding)	0.177	**2.84**	**0.64**	**12.96**
If Irregular (Not Applicable) – Ref	-	-	-	-
Cultural health practices (Yes)	0.736	1.27	0.31	5.23
Cultural health practices (No) – Ref	-	-	-	-
if yes (Bland diet)	0.898	0.93	0.31	2.77
if yes (Avoid Non-veg)	0.808	1.24	0.25	7.22
if yes (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned Table 4.3.2(c) shows that none of the variable had statistically significant odds for having urinary incontinence, but the odds were high for women having in regular painful menstruation, abnormal heavy bleeding for having urinary incontinence in comparison with light or infrequent menstrual bleeding .

Table 4.3.2(d): Binomial Logistic regression scores of menstrual history of migrant women having Anemia

N=100

Menstrual history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Age at menarche (10 -13 years) – Ref	-	-	-	-
Age at menarche (14 -16 years)	.260	0.30	0.04	2.38
Menstrual cycle (Regular) – Ref	-	-	-	-
Menstrual cycle (Irregular)	.999	0.00	0.00	.
If Regular (25 days once) – Ref	-	-	-	-
If Regular (28 - 30 days once)	.953	1.07	0.09	12.15
If Regular (31 - 35 days once)	.881	1.18	0.13	10.64
If Regular (36 - 40 days once)	.999	0.00	0.00	.
If Regular (Not Applicable)	-	-	-	-
If Irregular (Light or infrequent menstrual bleeding) – Ref	-	-	-	-
If Irregular (Painful menstruation)	.999	0.00	0.00	-
If Irregular (Abnormal heavy bleeding)	.998	0.00	0.00	-
If Irregular (Not Applicable) – Ref	-	-	-	-
Cultural health practices (Yes)	**.816**	**1.44**	**0.66**	**31.69**
Cultural health practices (No) – Ref	-	-	-	-
if yes (Bland diet)	**.562**	**1.74**	**0.28**	**11.29**
if yes (Avoid Non-veg)	.998	0.00	0.00	-
if yes (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.2(d) shows that none of the variable had statistically significant odds for having anemia, but the odds were high in women with cultural health practices such as having of bland diet during menstruation for having anemia in comparison of women who are not following the cultural health practices.

Table 4.3.2(e): Binomial Logistic regression scores of menstrual history of migrant women having Breast problems

N=100

Menstrual history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Age at menarche (10 -13 years) – Ref	-	-	-	-
Age at menarche (14 -16 years)	.400	0.57	0.15	2.08
Menstrual cycle (Regular) – Ref	-	-	-	-
Menstrual cycle (Irregular)	**.561**	**1.79**	**0.26**	**11.81**
If Regular (25 days once) – Ref	-	-	-	-
If Regular (28 - 30 days once)	.826	1.18	0.27	5.13
If Regular (31 - 35 days once)	**.111**	**8.63**	**0.69**	**122.39**
If Regular (36 - 40 days once)	.999	0.00	0.00	.
If Regular (Not Applicable)	-	-	-	-
If Irregular (Light or infrequent menstrual bleeding) – Ref	-	-	-	-
If Irregular (Painful menstruation)	.308	0.45	0.10	2.06
If Irregular (Abnormal heavy bleeding)	.642	0.69	0.14	3.29
If Irregular (Not Applicable) – Ref	-	-	-	-
Cultural health practices (Yes)	.786	0.81	0.17	3.71
Cultural health practices (No) – Ref	-	-	-	-
if yes (Bland diet)	.963	0.97	0.31	3.00
if yes (Avoid Non-veg)	.084	0.08	0.00	1.39
if yes (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.2.(e) shows that none of the variable had statistically significant odds for having breast problems, but the odds were high in women with history of menstrual irregularity for having breast problems in comparison of with women having regular menstrual cycle. Women with duration of menstruation (31-35) days had the high odds in comparison of 25 days of menstruation for having breast problems.

Table 4.3.3(a): Binomial Logistic regression scores of menstrual hygiene of migrant women of menstrual irregularities

N=100

Menstrual hygiene	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Duration of menstruation (3 -5 days) – Ref	-	-	-	-
Duration of menstruation (6 -7 days)	**.383**	**1.49**	**.604**	**3.77**
Duration of menstruation (8 -9 days)	.959	1.05	0.13	8.32
Duration of menstruation (10 -11 days)	.999	0.00	0.00	
Type of napkins (Sanitary napkins) – Ref	-	-	-	-
Type of napkins (Waste cloths)	.869	0.92	0.36	2.34
Change of pad (Once a day) – Ref	-	-	-	-
Change of pad (Twice a day)	**.088**	**2.39**	**0.88**	**6.38**
Change of pad (Thrice a day)	.884	**1.17**	**.141**	**9.78**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.3(a) shows that none of the variable had statistically significant odds for having menstrual irregularity, but the odds were high for women having (6-7) days duration of menstruation for having menstrual irregularity in comparison with (3-5) days duration of menstruation. Women changing the pad twice a day were having high odds in comparison of changing the pad once a day for having menstrual irregularity.

Table 4.3.3(b): Binomial Logistic regression scores of menstrual hygiene of migrant women having reproductive tract infection

N=100

Menstrual hygiene	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Duration of menstruation (3 -5 days) – Ref	-	-	-	-
Duration of menstruation (6 -7 days)	.535	0.75	0.30	1.86
Duration of menstruation (8 -9 days)	.970	**0.96**	**0.19**	**7.78**
Duration of menstruation (10 -11 days)	1.000	0.00	0.00	.
Type of napkins (Sanitary napkins) – Ref	-	-	-	-
Type of napkins (Waste cloths)	**.527**	**1.349**	**.533**	**3.41**
Change of pad (Once a day) – Ref	-	-	-	-
Change of pad (Twice a day)	.450	0.68	0.25	1.82
Change of pad (Thrice a day)	.240	0.28	0.03	2.32

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.3(b) shows that none of the variable had statistically significant odds for having reproductive tract infection, but the odds were high in women (8-9) days duration of menstruation were high reproductive tract infection in comparison with (3-5) days of menstruation. Women with using the waste cloth during menstruation were having the high odds then using the sanitary napkins.

Table 4.3.3(c): Binomial Logistic regression scores of menstrual hygiene and having urinary incontinence

N=100

Menstrual hygiene	Sig.	Odds Ratio	95% C.I. For Odds	
			Lower	Upper
Duration of menstruation (3 -5 days) – Ref	-	-	-	-
Duration of menstruation (6 -7 days)	.737	0.85	0.34	2.13
Duration of menstruation (8 -9 days)	.510	0.47	0.05	4.35
Duration of menstruation (10 -11 days)	1.00	0.00	0.00	.
Type of napkins (Sanitary napkins) – Ref	-	-	-	-
Type of napkins (Waste cloths)	**.071**	**0.39**	**0.14**	**1.08**
Change of pad (Once a day) – Ref	-	-	-	-
Change of pad (Twice a day)	.604	1.28	0.49	3.30
Change of pad (Thrice a day)	.354	0.34	0.03	3.33

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.3.(c) shows that none of the variable had statistically significant odds for having urinary incontinence , but the odds were high in women change the pad twice a day for having urinary incontinence in comparison of women with changing the pad once a day.

Table 4.3.3(d): Binomial Logistic regression scores of menstrual hygiene of migrant women having Anemia

N=100

Menstrual hygiene	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Duration of menstruation (3 -5 days) – Ref	-	-	-	-
Duration of menstruation (6 -7 days)	.730	0.76	0.16	3.51
Duration of menstruation (8 -9 days)	.999	0.00	0.00	.
Duration of menstruation (10 -11 days)	1.000	0.00	0.00	.
Type of napkins (Sanitary napkins) – Ref	-	-	-	-
Type of napkins (Waste cloths)	.384	0.38	0.04	3.34
Change of pad (Once a day) – Ref	-	-	-	-
Change of pad (Twice a day)	.594	**1.53**	**.330**	**6.99**
Change of pad (Thrice a day)	.999	0.00	0.00	.

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.3(d) shows that none of the variable had statistically significant odds for having anemia , but the odds were high in changing the pad twice a day for having the anemia in comparison of changing the pad once a day.

Table 4.3.3(e): Binomial Logistic regression scores of menstrual hygiene of migrant women having breast problems

N=100

Menstrual hygiene	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Duration of menstruation (3 -5 days) – Ref	-	-	-	-
Duration of menstruation (6 -7 days)	**.209**	**1.83**	**0.77**	**4.58**
Duration of menstruation (8 -9 days)	.752	0.71	0.09	5.68
Duration of menstruation (10 -11 days)	1.000	0.00	0.00	.
Type of napkins (Sanitary napkins) – Ref	-	-	-	-
Type of napkins (Waste cloths)	**0.587**	**1.32**	**0.52**	**3.39**
Change of pad (Once a day) – Ref	-	-	-	-
Change of pad (Twice a day)	**.030***	**3.29**	**1.18**	**9.23**
Change of pad (Thrice a day)	**.125**	**5.34**	**0.66**	**45.55**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.3(e) shows that none of the variable had statistically significant odds for having breast problems, but the odds were high in women having (6-7) days duration of menstruation for having the breast problems in comparison with women who had less than (3-5) days of menstruation, those who used the waste cloths during the menstruation had high odds for breast problems in comparison of using sanitary napkin women who changed the pad twice a day had statistical significant odds in comparison of changing the pad once a day for having breast problems.

Table 4.3.4(a): Binomial Logistic regression scores of marital history of migrant women having menstrual irregularities.

N=100

Marital history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Marital status (Living with spouse) – Ref	-	-	-	-
Marital status (Separated)	.604	0.71	0.19	2.58
Age at marriage (15 -17 years)	.300	**2.15**	**0.507**	**9.73**
Age at marriage (18 -20years) – Ref	-	-	-	-
Duration of marriage (< 5 years) – Ref	-	-	-	-
Duration of marriage (6 -10 years)	.180	**3.86**	**0.55**	**27.84**
Duration of marriage (11 -15 years)	.345	**2.45**	**0.38**	**15.74**
Duration of marriage (16 -20 years)	**.010****	**13.14**	**1.87**	**91.66**
Duration of marriage (> 20 years)	**.005****	**31.47**	**2.78**	**354.86**
Age at first child birth (14-17 years)	.446	0.61	0.17	2.14
Age at first child birth (18-21 years)	.229	**5.37**	**0.38**	**82.96**
Age at first child birth (Not Applicable) - Ref	-	-	-	-
History of abortion (Yes)	.472	0.339	0.018	6.455
History of abortion (No) – Ref	-	-	-	-
Type of abortion (legal)	.246	**5.87**	**0.294**	**117.49**
Type of abortion (illegal)	-	-	-	-
Type of abortion (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.4(a) describes that the odds ratio of the of migrant women for having menstrual irregularity women having between age (15-17) years, were high odds for menstrual irregularity with reference women between (18-20) years .Women with duration of marriage age (6-10) years, (11-15) years, were having high odds and age (16-20)years, >20 years were having highly statistically significant in comparison of age less than 5 years.>20 years for having menstrual irregularity were statistical significant in comparison of less than 5 years. Though not statistically significant the odds of women with legal abortion was high compared to no history of abortion.

Table 4.3.4(b): Binomial Logistic regression scores of marital history of migrant women having reproductive tract infection

N=100

Marital history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Marital status (Living with spouse) – Ref	-	-	-	-
Marital status (Separated)	.235	**2.35**	**.574**	**9.58**
Age at marriage (15 -17 years)	.333	0.48	0.10	2.12
Age at marriage (18 -20years) – Ref	-	-	-	-
Duration of marriage (< 5 years) – Ref	-	-	-	-
Duration of marriage (6 -10 years)	.473	0.531	0.095	2.98
Duration of marriage (11 -15 years)	.244	**2.48**	**0.54**	**11.29**
Duration of marriage (16 -20 years)	.178	**2.99**	**0.68**	**14.77**
Duration of marriage (> 20 years)	.124	**4.78**	**.651**	**35.18**
Age at first child birth (14-17 years)	.998	1.00	0.29	3.37
Age at first child birth (18-21 years)	.849	0.80	0.08	7.46
Age at first child birth (Not Applicable) – Ref	-	-	-	-
History of abortion (Yes)	.625	0.50	0.03	7.74
History of abortion (No) – Ref	-	-	-	-
Type of abortion (legal)	.235	**5.43**	**.335**	**87.26**
Type of abortion (illegal)	-	-	-	-
Type of abortion (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.4(b) shows that none of the variable had statistically significant odds for having reproductive tract infection , but the odds were high in women who are separated for having the reproductive tract infection in comparison of women living with spouse. Women with duration of marriage 11-15 years, 16-20 years and >20 years had high odds for having reproductive tract infection in comparison of women with duration of marriage less than 5 years. Though not statistically significant the odds of women with legal abortion was high compared to no history of abortion for having reproductive tract infection.

Table 4.3.4(c): Binomial Logistic regression scores of marital history of migrant women having urinary incontinence

N=100

Marital history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Marital status (Living with spouse) – Ref	-	-	-	-
Marital status (Separated)	.612	1.38	0.39	4.87
Age at marriage (15 -17 years)	.937	1.05	0.29	3.69
Age at marriage (18 -20years) – Ref	-	-	-	-
Duration of marriage (< 5 years) – Ref	-	-	-	-
Duration of marriage (6 -10 years)	.383	**2.68**	**0.44**	**10.59**
Duration of marriage (11 -15 years)	.708	**1.36**	**0.33**	**5.79**
Duration of marriage (16 -20 years)	.795	**1.23**	**0.28**	**5.57**
Duration of marriage (> 20 years)	.154	**4.54**	**0.58**	**36.29**
Age at first child birth (14-17 years)	.408	0.62	0.20	1.91
Age at first child birth (18-21 years)	.877	0.84	0.10	7.15
Age at first child birth (Not Applicable) – Ref	-	-	-	-
History of abortion (Yes)	.999	0.00	0.00	-
History of abortion (No) – Ref	-	-	-	-
Type of abortion (legal)	.999	0.00	0.00	-
Type of abortion (illegal)	-	-	-	-
Type of abortion (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.4(c) shows that none of the variable had statistically significant odds for having urinary incontinence, but the odds were high in women with duration of marriage 6-10 years 11-15 years 16-20 years and>20 years had high odds for having urinary incontinence in comparison of women duration of marriage less than 5 years.

Table 4.3.4(d): Binomial Logistic regression scores of marital history of migrant women having anemia

N=100

Marital history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Marital status (Living with spouse) – Ref	-	-	-	-
Marital status (Separated)	.853	0.78	0.05	10.38
Age at marriage (15 -17 years)	.998	0.00	0.00	.
Age at marriage (18 -20years) – Ref	-	-	-	-
Duration of marriage (< 5 years) – Ref	-	-	-	-
Duration of marriage (6 -10 years)	**.014****	**50.75**	**2.20**	**1168.94**
Duration of marriage (11 -15 years)	**.007****	**62.86**	**3.87**	**1278.81**
Duration of marriage (16 -20 years)	.998	0.00	0.00	.
Duration of marriage (> 20 years)	**.110**	**11.31**	**0.58**	**208.92**
Age at first child birth (14-17 years)	.998	0.00	0.00	.
Age at first child birth (18-21 years)	.998	0.00	0.00	.
Age at first child birth (Not Applicable) – Ref	-	-	-	-
History of abortion (Yes)	.999	0.00	0.00	-
History of abortion (No) – Ref	-	-	-	-
Type of abortion (legal)	.999	0.00	0.00	-
Type of abortion (illegal)	-	-	-	-
Type of abortion (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.4(d) describes that the odds of the women between 6-10 years, 11-15 years duration of marriage had statistically significant odds for having anemia with reference to women with duration of marriage less than 5 years , and above 20 years were high in comparison with duration of marriage less than 5years.

Table 4.3.4(e): Binomial Logistic regression scores of marital history of migrant women having breast problems

N=100

Marital history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Marital status (Living with spouse) – Ref	-	-	-	-
Marital status (Separated)	.810	0.85	0.24	3.05
Age at marriage (15 -17 years)	.833	0.87	0.25	3.03
Age at marriage (18 -20years) – Ref	-	-	-	-
Duration of marriage (< 5 years) – Ref	-	-	-	-
Duration of marriage (6 -10 years)	.660	**1.45**	**0.27**	**7.66**
Duration of marriage (11 -15 years)	.569	**1.55**	**0.34**	**7.24**
Duration of marriage (16 -20 years)	.849	**1.16**	**0.24**	**5.65**
Duration of marriage (> 20 years)	.845	**1.21**	**0.18**	**8.27**
Age at first child birth (14-17 years)	.232	**1.99**	**0.66**	**6.59**
Age at first child birth (18-21 years)	.125	**6.69**	**0.59**	**75.24**
Age at first child birth (Not Applicable) – Ref	-	-	-	-
History of abortion (Yes)	.314	**3.68**	**0.29**	**46.73**
History of abortion (No) – Ref	-	-	-	-
Type of abortion (legal)	.384	0.32	0.02	4.15
Type of abortion (illegal)	-	-	-	-
Type of abortion (Not Applicable) – Ref	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.4(e) describes that none of the variable had statistically significant odds for having breast problems but the odds were high for women between 6-10 years, 11-15years, 16-20 years, >20 years duration of marriage for having breast problems in comparison of women with duration of marriage less than 5 years. Women between 14-17 years, 18-21years age at first child birth had high odds for having breast problems in comparison in no history of birth.

Table 4.3.5(a): Binomial Logistic regression scores of sexual and contraceptive history of migrant women having menstrual irregularities

N=100

Sexual and Contraceptive history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Frequency of coitus (Once a while) – Ref	-	**-**	**-**	**-**
Frequency of coitus (Weekly once)	.861	0.90	0.27	2.91
Frequency of coitus (Two times a week)	.794	0.82	0.18	3.59
Frequency of coitus (3-4 times per week)	.928	**1.43**	**0.63**	**20.67**
Frequency of coitus (>5 times per week)	.936	**1.59**	**0.26**	**4.93**
Frequency of coitus (Not Applicable)	.505	**1.52**	**0.44**	**5.26**
Contraceptive measures (Yes) – Ref	-	**-**	**-**	**-**
Contraceptive measures (No)	.735	1.18	0.44	3.15
If yes (Permanent method) – Ref	-	**-**	**-**	**-**
If yes (Temporary method)	.183	**2.70**	**0.71**	**6.39**
If yes (Not Applicable)	-	**-**	**-**	**-**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.5(a) describes that none of the variable had statistically significant odds for having menstrual irregularity but the odds were high for women having frequency of coitus between 3-4 times /week,>5 time /week, and no coitus for having high odds for menstrual irregularity comparison of women had once a while of coitus. Women using temporary contraceptive methods had high odds for having menstrual irregularity compared to women using permanent method.

Table 4.3.5(b): Binomial Logistic regression scores of sexual and contraceptive history of migrant women having reproductive tract infection

N=100

Sexual and Contraceptive history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Frequency of coitus (Once a while) – Ref	-	**-**	**-**	**-**
Frequency of coitus (Weekly once)	.546	**1.49**	**0.46**	**4.89**
Frequency of coitus (Two times a week)	.456	0.57	0.13	2.49
Frequency of coitus (3-4 times per week)	.820	0.71	0.03	12.96
Frequency of coitus (>5 times per week)	.873	1.12	0.27	4.65
Frequency of coitus (Not Applicable)	.269	**2.11**	**0.56**	**7.94**
Contraceptive measures (Yes) – Ref	-	**-**	**-**	**-**
Contraceptive measures (No)	.400	**1.57**	**0.56**	**4.18**
If yes (Permanent method) – Ref	-	**-**	**-**	**-**
If yes (Temporary method)	.247	**1.93**	**0.64**	**5.66**
If yes (Not Applicable)	-	**-**	**-**	**-**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.5(b) describes that none of the variable had statistically significant odds for having reproductive tract infection but the odds ratio were high for women with frequency of coitus weekly once and no coitus for having high odds for reproductive tract infection comparison of once a while of coitus. Women who are not using any contraceptive methods and temporary contraceptive methods were having high odds reproductive tract infection in comparison with women using permanent method.

Table 4.3.5(c): Binomial Logistic regression scores of sexual and contraceptive history of migrant women having urinary incontinence

N=100

Sexual and Contraceptive history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Frequency of coitus (Once a while) – Ref	-	-	-	-
Frequency of coitus (Weekly once)	.699	0.79	0.24	2.55
Frequency of coitus (Two times a week)	.719	1.31	0.30	5.70
Frequency of coitus (3-4 times per week)	.928	1.14	0.06	20.66
Frequency of coitus (>5 times per week)	.243	**2.48**	**0.56**	**10.89**
Frequency of coitus (Not Applicable)	.337	**1.85**	**0.57**	**6.50**
Contraceptive measures (Yes) – Ref	-	-	-	-
Contraceptive measures (No)	.777	0.86	0.32	2.33
If yes (Permanent method) – Ref	-	-	-	-
If yes (Temporary method)	.747	1.19	0.41	3.46
If yes (Not Applicable)	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.5(c) describes that none of the variable had statistically significant odds for having urinary incontinence but the odds were high for women having frequency of coitus between >5 times / week, and no coitus for having high odds for urinary incontinence in comparison of once a while of coitus.

Table 4.3.5(d): Binomial Logistic regression scores of sexual and contraceptive history of migrant women having anemia

N=100

Sexual and Contraceptive history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Frequency of coitus (Once a while) – Ref	-	-	-	-
Frequency of coitus (Weekly once)	.998	0.00	0.00	.
Frequency of coitus (Two times a week)	.999	0.00	0.00	.
Frequency of coitus (3-4 times per week)	.460	0.32	0.01	6.52
Frequency of coitus (>5 times per week)	.999	0.00	0.00	.
Frequency of coitus (Not Applicable)	.351	2.90	0.30	27.34
Contraceptive measures (Yes) – Ref	-	-	-	-
Contraceptive measures (No)	.614	0.65	0.12	3.43
If yes (Permanent method) – Ref	-	-	-	-
If yes (Temporary method)	.999	0.00	0.00	.
If yes (Not Applicable)	-	-	-	-

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.5(d) describes that none of the variable had statistically significant odds for having anemia but the odds were high for women having no frequency of coitus for having high odds for anemia in comparison of once a while of coitus.

Table 4.3.5(e): Binomial Logistic regression scores of sexual and contraceptive history of migrant women having breast problems

N=100

Sexual and Contraceptive history	Sig.	Odds Ratio	95% C.I. for Odds	
			Lower	Upper
Frequency of coitus (Once a while) - Ref	-	**-**	**-**	**-**
Frequency of coitus (Weekly once)	**.047***	**0.19**	**0.39**	**0.97**
Frequency of coitus (Two times a week)	.928	1.07	0.24	4.69
Frequency of coitus (3-4 times per week)	.999	0.00	0.00	.
Frequency of coitus (>5 times per week)	.133	**3.16**	**0.73**	**14.27**
Frequency of coitus (Not Applicable)	.670	0.76	0.21	2.67
Contraceptive measures (Yes) - Ref	-	**-**	**-**	**-**
Contraceptive measures (No)	.957	0.97	0.33	2.82
If yes (Permanent method) - Ref	-	**-**	**-**	**-**
If yes (Temporary method)	.479	**1.49**	**0.49**	**4.55**
If yes (Not Applicable)	-	**-**	**-**	**-**

Ref – Reference category, ***- Significant at p<0.001, ** - Significant at p<0.01, *- Significant at p<0.05.

Above mentioned table 4.3.5(e) describes that the odds of the women having the frequency of coitus weekly once for having high odds for breast problems in comparison of women having a once a while is statistically significant. Women with contraceptive methods in temporary for having high odds for breast problems in comparison of women with permanent contraceptive methods.

CHAPTER – 5

DISCUSSION

DISCUSSION

This chapter deals with the discussion on the findings of the study interpreted from the statistical analysis. The findings are discussed in relation to the objectives, need for the study, related literature, conceptual framework and research hypothesis specified in the study. It is presented in line with the objectives of the study.

5.1 The description of the demographic variables among Migrant women population in Thiruvallur District

The demographic variables of the migrant women population considered in this study was age, education, occupation, monthly family income, type of family, religion, menstrual history, marital status, parity, diet pattern, contraceptive usage, and history of abortion.

Most of the women were between the age group of 30-34years, Non-literates, majority of them were skilled workers and getting monthly income of Rs.1803-5386 and they were from nuclear family, belongs to Hindu religion.

The majority of the women had conceived 3-4 times and they underwent 3-4 deliveries, currently having 3-4 children and with the history of 1-2 episode of legal abortion and most of the women had their menstruation for 3-5days; the type of napkin they used were waste cloths and they used to change their pad twice a day.

Almost all the women were married and they were living with their spouse, age of marriage was 15-17 years, and the duration of married life was between 11-15 years. Most of the women had frequency of coitus once in a while. Majority of them delivered their first child between age of 15-17 years and they had undergone permanent sterilization.

5.2 The first objective was to assess the reproductive health problems of migrant women population

The frequency and percentage distribution of the above mentioned objective are as follows,

5.2.1 Menstrual irregularity

The table 4.2.1 depicted that majority of the women attained menarche between 10-13 years, with the history of irregular menstrual cycle and most of them had experienced painful menstruation and followed bland diet as a cultural practice for relieving pain. The findings was supported by (N. Karout 2010; S.M. Hawai,2010) a quasi-experimental study to determine the prevalence and pattern of menstrual irregularity symptoms among 60 migrant women in reproductive age group by using a structured interview schedule. The findings revealed that the most common menstrual disorders were irregular frequency of menstruation (80.7%), premenstrual syndrome (54.0%), and irregular duration of menstruation (43.8%), dysmenorrhoea (38.1%), polymenorrhoea (37.5%) and oligomenorrhoea (19.3%).

5.2.2 Reproductive tract infection

The table 4.2.2 depicted that few women had frequent rise of temperature, many of them experienced back pain accompanied by white discharge which was creamy and sticky in consistency with fishy smell and it occurred during the mid-menstrual cycle with the desire to scratch the skin often and many women used white hibiscus flower as a cultural practice to reduce white discharge.

This findings was supported by couple of researchers (Melani, 2010; Savitha B Guptha et al ,2011) reported in their comparative study to assess the prevalence of reproductive tract infection among migrant women and rural women in tribal areas in Maharashtra, by used structured interview schedule. The prevalence of reproductive tract infection includes the symptoms of leucorrhoea, itching, genital lesion, and lower abdominal pain.

5.2.3 Urinary incontinence

The table 4.2.3 depicted that in consideration to urinary incontinence most of the women had urinary incontinence during sneezing. This findings was supported by Numerous studies (Parashar, BP, 2010; Gupdha AK 2011; Bhardwaj, 2012) which revealed that child bearing at a young age, high parity and poor access to medical facilities as the most important leading cause to high prevalence of reproductive problems in association to the life style of migrant women in community. The results

revealed that the common problems were cystocele, uterine prolapse, rectocele, cervical erosion, inflammation, urinary incontinence and dyspareunia.

5.2.4 Anemia

The table 4.2.3 depicted that most of the migrant women had tiredness, pale conjunctiva, pale finger nail and brittle nails whereas few women had shortness of breath, palpitation, and grade I leg swelling. Most of the women had the practice of taking green leafy vegetables for anemia, none of them had the habit of taking dewarming tablets every six months. This was supported by researches (Piombol L, Scardella P, et al, 2011) which explored the prevalence of anemia among migrant women in Kanchipuram district. A total of830 samples, were selected using non-probability purposive sampling technique. Laboratory screening was done to 821 samples, which concluded that 90% of migrant women had anemia in common.

5.2.5 Breast problems

The table 4.2.4 depicted that many women had breast problem, in that few had lump, pain and swelling in the breast, very few women had dimpling and nipple retraction, redness of nipple, scaly nipple and skin irritation. None of them had nipple discharge, whereas very few women had family history of breast problem such as mastalgia. This findings was supported by series of researchers (Samuel Shapiro 2010; Arthur Schatzkin, Julie R. Palmer 2010; David Kaufman et al 2012;Lynn Rosenberg 2012; Helmrich et,al 2013)who conducted explorative studies to evaluate risk factors for breast problems among the migrant women in various hospitals. The risk for breast problems were advanced age of first child birth and late age of menarche and this was associated with a risk of lump and pain among migrant women.

Van cleemputp 2010; Parry G, 2012 conducted a descriptive studies who found that migrant women were vulnerable to develop reproductive health problems. The major problems were leucorrhoea, menstrual irregularity, breast problems, and anemia. The findings was supported by Holy J, Rogers A, et al;(2012)who explored the prevalence of reproductive health problems among nomadic tribes of Rajasthan state in India, to study the prevalence rate of reproductive health problems. The study involved about 1286 participants. Information regarding reproductive health problems such as reproductive tract infections, urinary incontinence, anemia, among the study population was obtained

through questionnaires. Results showed that the prevalence of anemia and leucorrhea were the common problems among them.

The investigator adopted the conceptual framework based on **Betty Newman's System Model** which was used to identify the precipitating factors for reproductive health problems. The dynamic interaction between person and their environment was clearly depicted in this model. The investigator perceived that there is a need to focus reproductive health problems among migrant women in order to provide appropriate treatment and to prevent complications.

5.3 The second objective was to identify the precipitating factors for reproductive health problems among migrant women populations in Thiruvallur.

5.3.1 Precipitating factor for menstrual irregularity

The women between the age group of (35-39) years, (40-44) years had irregular menstrual cycle, religion were Christian,6-7 days of menstruation, duration of marriage is 20 years, age at first child birth is 18-21 years and history of legal abortion. Those under the age group of 35-39 years belongs to pre-menopausal, there by their frequency of menstrual cycle is increasing. Their marital life is 20 years with the history of legal abortion and frequency of coitus more than 5 times.This findings was supported by (Sadhna Singh, 2012; Teresa Cue, et al 2011; Longchangxg, Kirbaann, et al 2012; Loreta,P, Rinu, et al 2013) descriptive studies conducted to assess the menstrual irregularity among migrant women population who were married in Rajasthan by using convenient sampling technique. They found that there is irregular menstrual cycle among women in the age of 35-40 years and with the history of abortion.

5.3.2 Precipitating factor for reproductive tract infection

Women between (30-34) years, family monthly income(Rs.5387-8982), avoid non-veg, using waste cloth during menstruation, duration of marriage, history of legal abortion, frequency of coitus, using temporary contraceptive devices.The utilization of waste cloths during menstruation causes infection, since they are using contraceptive measures leading to unhygienic practices and further infection and those who underwent invasive procedures (legal abortion) are more open to reproductive tract infection. Nicolus.F 2012; Hendry, 2013 conducted a cross-sectional study to assess the risk factors of leucorrhoea among nomadic tribes using a knowledge questionnaire and non-

probability sampling technique. The findings showed that the lack of sexual hygiene practices were leading cause to these problems.

5.3.3 Precipitating factor for urinary incontinence

The women between 40-44 years, irregular menstrual cycle, abnormal heavy bleeding, avoiding non-veg during menstruation, above 20 years of duration of marriage, frequency of coitus more than 5 times. So, with an increasing age there is alteration in neurological systems so drippling can happen. Fredrick 2011; Wesley .l 2012; Kasthuri ,2013) conducted a community based cross-sectional studies reporting that urinary incontinence prevalence was found significantly more in married female migrants as compared to unmarried in reproductive age group women in urban communities. They found that urinary incontinence was present more in married women of lower socioeconomic status and with high parity.

5.3.4 Precipitating factor for anemia

Women between (30-34) years (25-29) years, Hindu religion, cultural health practices, following bland diet during menstruation, duration of marriage (11-15) years. Young age group having abnormal heavy bleeding, poor eating habits, increasing number of deliveries in young age were the leading cause of anemia. Supportive study was conducted by Finlay Jonah 2012, Martina, Masilamani, (2013) as a descriptive study among adolescents girls in migrants who are vulnerable to anemia in rural area by using check list and hemoglobin estimation. It was done for about 100 girls through cyanmethglobin method. The results shown that nearly half of the population were having anemia.

5.3.5 Precipitating factor for breast problems

The women between (25-29) years, skilled worker(selling beads), regular menstrual cycle(31-35), duration of menstruation (6-7) days, age at first child birth as 18-21 years, history of abortion, frequency of coitus more than 5 times, temporary contraceptive measures.This findings supported by Indian Researchers (Sandhya .P, 2010; Sharddha.A, Bharti.B. M, Morgan; Ribbu 2011; Amrose et al, 2011) have supplemented their findings to the above factors stating that low socio economic status along with the environmental conditions will also influence reproductive health which is predominantly due to poor utilization of the reproductive and child health services

provided by the government, lack of awareness regarding birth spacing and very low use of contraceptives. Likewise, education regarding breast self -examination and proper follow up is necessary to prevent and also considered a early treatment for women in child bearing age who were prone to get fibroadenoma, fibroadenosis, breast abscess, sebaceous cyst, duct papilloma and lipoma etc.

Hence the research hypothesis **RH: There are significant precipitating factors for reproductive health problems among migrant women was accepted for the above health problems.**

CHAPTER – 6

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

SUMMARY, CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

This chapter presents the summary, conclusion, implications, plan for research utilization, recommendations, plan for research dissemination and limitations of the study.

6.1 SUMMARY

Women's health is considered as a fundamental human right and a worldwide social quality of life. A healthy woman is an asset to the society and they are the basic foundation of the society and its wealth. Particularly the migrant population faces many health problems due to mobility, low socio economic status, cultural barrier and lack of knowledge on health care services. The reproductive health problems which affects the reproductive age women includes menstrual irregularity, endometriosis, uterine fibroids, gynaecology cancer, polycystic ovarian cancer, unsafe abortion, sexually transmitted diseases and infertility.

Reproductive health problems are the leading cause of women's ill health and death worldwide. The considerable challenges continue to exist in the area of sexual and reproductive health. Death and disability due to sexual and reproductive health accounted for 18 per cent of the total disease burden globally and 32 per cent of the disease burden among women of reproductive age in 2014 (Economic and Social Commission for Asia and Pacific). Hence the investigators find that Women are the backbone of the society. Women health is everyone's health. So the health care professionals must provide awareness about risk factors of reproductive health problems among migrant women focussing on sexual health concerns, contraceptive use and utilization of other reproductive health services.

The objectives of the study was

1. To assess the reproductive health problem among migrant women.
2. To identify the precipitating factors for reproductive health problems among migrant women population.

The hypotheses formulated were

RH: There is a significant precipitating factors for reproductive health problems among migrant women population at $p<0.05$.

The review of literature was collected from varied primary and secondary sources, along with personal and professional experience and expert's opinion from the field of obstetrical and gynaecological nursing, community health nursing and provided an ample framework for the selection of the problem and accomplishing the objectives of the study. It also contributed the ideas for framing the conceptual framework, methodology and for the development of the tool for data collection. The conceptual framework for the study was based on **Betty Newman's System Model,** which established a comprehensive framework for assessing the reproductive health problems among migrant women.

Quantitative research approach and Non-experimental descriptive research design was adopted by the nurse investigator to assess the reproductive health problems among migrant women population. The investigator conducted the study by selecting 100 samples, who fulfilled the inclusion criteria by using non-probability convenient sampling technique.

The content validity of the data collection tool was obtained from 2 medical experts and 3 Nursing experts in the field of Obstetrician and Gynecology. The reliability of the tool was assessed using inter-rater method and score was $r = 0.8$. Reliability and pilot study indicated that the tool was reliable for proceeding the study.

Throughout the research study the ethical aspect was maintained by obtaining the ethical clearance certificate from the ICCR. A formal permission was obtained from the Principal, Omayal Achi college of Nursing, and Ward member of the Athigathur Panchayat, Thiruvallur District.The main study was conducted at migrant's temporary settlement area at Pinjivakkam, Thiruvallur District in the month of May 2016.

The structured interview schedule was used for data collection. Data collected were analyzed and interpreted based on the formulated objective and hypotheses using descriptive and inferential statistics.

The major findings of the study

There as significant of reproductive health problems and its precipitating factors for among migrant women population.

- Women in the age group of (35-39) years, (40-44) years had irregular menstrual cycles, who were Christians, who had 6-7 days duration of menstruation, with 20 years of duration of marital life, first child birth in the age of 18-21 years and history of legal abortion were the precipitating factors for menstrual irregularities with the 52%..
- Women between (30-34) years of age, using waste cloth during menstruation with the history of legal abortion, having coitus more than 5 times/week, using temporary contraceptive devices were the precipitating factors for reproductive tract infection with the 47%.
- Women between (40-44) years of age had irregular menstrual cycle (abnormal heavy bleeding), who experienced more than 20 years of marital life with practice of coitus more than 5 times/week were the precipitating factors for urinary incontinence with the 57%.
- Women between (30-34) years (25-29) years of age, belonging to Hindu religion, who follows bland diet during menstruation as a cultural practice were the precipitating factors for anemia with the 85%.
- Women between the age (25-29) years, skilled worker (selling beads), with history of regular menstrual cycle (31-35),in the duration of (6-7) days of menstruation, who had (18-21) years, first child birth in the age of (18-21), history of abortion, who had coitus more than 5 times/week, using contraceptive measures temporary were the precipitating factors for breast problems with the 43%.

6.2 CONCLUSION

The present study aimed at assessing the reproductive health problems among migrant women population. The investigator identified that reproductive health problems such as Menstrual irregularity(52%), Reproductive tract infection(47%), Urinary incontinence(56%), Anemia(85%) and Breast problems(43%) were present and identified the following precipitating factors in reproductive health problems among migrant women were such as, duration of menstruation more than 6-7 days, using waste

cloth during menstruation, changing the pad, age at marriage, age at first child birth, frequency of coitus, history of legal abortion, cultural health practices from this the investigator identified the reproductive health problems and precipitating factors of migrant women. The study findings revealed that the selected risk factors shows statistically significant odds ratio. Hence the researcher recommends that mass awareness and screening programme can be initiated to reduce the magnitude of reproductive health problems among migrant women.

6.3 IMPLICATIONS

The researcher has drawn the following implications from the study, in the field of nursing practice, nursing administrations, nursing education and nursing research.

6.3.1 Nursing Practice

A nurse being a vital part of the health care team holds responsibility in assessing and educating the migrant women regarding the prevention of reproductive health problems. Hence they are in need of determining the precipitating factors in order to reduce the morbidity and mortality from reproductive health problems.

The means are as follows,

- Conduct the screening programs to assess the reproductive health problems and precipitating factors among migrant women in reproductive age group.
- Encourage personal hygiene and infection control practices through mass camp.
- To motivate healthy life practices such as personal health activity, dietary practices, perineal hygiene, menstrual hygiene, sexual hygiene through group health education.
- Organize frequent health camp to assess the reproductive health problems and initiate appropriate treatment for vulnerable and high risk groups.
- Nursing curriculum should include risk assessment strategies related to reproductive health problems

6.3.2 Nursing Education

- Nurse educator has the role in incorporating the evidence based guidelines into the nursing curriculum for improving the reproductive health.

- Student nurses should be trained in assessing and educating all reproductive women regarding reproductive health problems and its prevention.
- Conducts seminars, workshops and conferences for the students related to prevention strategies in order to enhance their knowledge and skills in caring population with reproductive health problems.

6.3.3 Nursing Administration

The nurse Administrator,

- Nurse administrators can plan and implement a protocol for nurses as an aid in enhancing the knowledge in prevention of reproductive health problems among migrant woman as a part of routine health care.
- Nurse administrators can plan for awareness programmes and reach-out to a larger group of population
- Should collaborate with the Government and Non-Governmental organisations to create policies and collects funds to conduct awareness campaign programme among migrant women.

6.3.4 Nursing Research

The nurse midwife researcher,

- The findings of the study can be disseminated to the nurses working in obstetrical and gynaecology nursing department and student nurses through various media.
- The identified precipitating factors can be incorporated in framing assessment criteria to screen the risk for reproductive health problems.
- The study plan can be further replicated in various other settings and larger migrant population.
- Should publish the findings of the study through paper/poster presentation in conferences, seminars and workshops.
- The generalization of the study result can be made by further publication of the study in various settings of migrant population.

6.4 RECOMMENDATIONS

The investigator recommends,

- The researcher will utilize the research findings of the study, to plan regular and periodical health screening in the migrant areas through the community health centers in Pinjivakkam.
- The researcher will motivate the migrant population to attend the reproductive health campaign, and adapt their life style into healthy practices to prevent their reproductive health problems
- A study can be conducted for identifying the role of each single risk factor towards the causation of reproductive health problems.
- A similar study can be conducted in a larger population and in different migrant temporary settlement areas.

6.5 LIMITATIONS

The investigator found

- Difficult to obtain setting permission for the study
- Some married women were hesitant to discuss about their personal information

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APPENDICES

Love to Serve
அறஞ்செய விரும்பு

INTERNATIONAL CENTRE FOR COLLABORATIVE RESEARCH
OMAYAL ACHI COLLEGE OF NURSING
Run by MR Omayal Achi MR Arunachalam Trust

ETHICAL CLEARANCE CERTIFICATE

Valid from: December 2014

Valid to : October 2016 (2 years)

Name of the Principle Investigator: Ms.Rosy.P, M.Sc. (N) Student (Obstetrics and Gynaecological Nursing)

The **ICCR** Ethical Committee meeting held on 22.12.2014 had reviewed the project titled **"A descriptive study to assess the Reproductive Health Problems among migrant women population at selected setting, Thiruvallur."** The proposal was found to be acceptable on ethical grounds. The Principle Investigator has the responsibility and accountability for any other administrative / regulatory approvals that may pertain to this research project and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review.

This certificate of approval is valid for the time period provided, there is no change in the methodology protocol or consent process and documents.

Any significant change should be reported to Director for Research Committee considerations in advance for its implementation.

Signature of Research Director :

Signature of Researcher : P. Rosy.

45, AMBATTUR ROAD, PUZHAL, CHENNAI - 600 066. TAMIL NADU, INDIA
Tel : 26591617, 26591618, Fax : 26591616, E-mail : iccrphc@gmail.com, Website : www.omayaln.com

OMAYAL ACHI COLLEGE OF NURSING

Run by MR. Omayal Achi MR.Arunachalam Trust

45, AMBATTUR ROAD, PUZHAL, CHENNAI - 600 066.
(Affiliated to the Tamilnadu Dr.M.G.R. Medical University
Recognized by the Indian Nursing Council & TN Nurses and Midwives Council)

Tel : 26591617, 26591618
Fax : 26591616
E-mail : oacn1992@gmail.com
Website : omayaln.com

Love to Serve
அறஞ்செய விரும்பு

19.05.2016.

The Ward Member,
Pinjivakkam,
Thiruvallur,
Chennai.

Sir/Madam,

Sub: Request for permission to conduct
Research Study.

Mrs. Rosy P, is a bonafide student of M.Sc(Nursing) I year studying at our College and she is conducting "A DESCRIPTIVE STUDY TO ASSESS THE REPRODUCTIVE HEALTH PROBLEMS AMONG MIGRANT WOMAN POPULATION AT SELECTED SETTINGS, THIRUVALLUR".

This is for her research project to be submitted to the Tamilnadu Dr.M.G.R. Medical University in partial fulfillment of the University requirement for the award of M.Sc(Nursing) Degree.

Further details of the proposed project will be furnished by the student personally. She will not hinder your routine in any way and she will abide by the rules and regulations of the Hospital. The information collected from your Hospital will be kept confidential.

I kindly request you to grant her permission to conduct the study at your Hospital.

Thanking you,

Yours Sincerely,
OMAYAL ACHI COLLEGE OF NURSING
Principal

தலைவர்
அதிகத்தூர் ஊராட்சி
கடம்பத்தூர் ஒன்றியம்
திருவள்ளூர் மாவட்டம்
அஞ்சல் எண் : 631203

APPENDIX – C

LETTER SEEKING EXPERT'S OPINION FOR CONTENT VALIDITY

From

Mrs. P. Rosy,
M.Sc.(N) II year,
Omayal Achi College of Nursing,
Puzhal, Chennai – 600 066.

To

Respected Madam/ Sir,

Sub: Requisition for expert opinion on suggestion for content validity of the tool.

I am **Mrs. P. Rosy.,** doing my M.Sc Nursing II year specializing in Obstetrics and Gynaecology Nursing at Omayal Achi College of Nursing under the guidance of Dr.Mrs.Kanchana, Principal and Research Director, ICCR and speciality Guide Mrs.T.Amutha, as a part of my research project to be submitted to the Tamil Nadu Dr.M.G.R. Medical University, Guindy, December 2014 session and in partial fulfilment of the University requirement for the award of M.Sc(N) degree, I am conducting **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Thiruvallur"2015.**

I have enclosed my data collection tool for your expert guidance and validation. Kindly do the needful.

Thanking You,

Yours faithfully,

(P. Rosy)

ENCLOSURES:

1. Research proposal
2. Data collection tool
3. Certificate and Content validity form

APPENDIX – C

LIST OF EXPERTS FOR CONTENT VALIDITY

MEDICAL EXPERTS:

1. **Dr.S.Lalitha, MBBS., DGO(O&G),HOD,**
   Department of Obstetrics and Gynecology,
   Sir Ivan Stedeford Hospital, Ambattur,
   Chennai-600 053, Tamil Nadu.

2. **Dr.(Mrs) Sucharitha D.G.O, DNB (O&G)., F.MAS.,**
   Medical Officer,
   Department of Obstetrics and Gynecology,
   Sir Ivan Stedeford Hospital,
   Ambattur, Chennai-600 053, Tamil Nadu.

NURSING EXPERTS:

1. **Dr.Nalini, M.Sc.,(N), Ph.D., (N)**
   Vice Principal,
   Sri Ramachandra College of Nursing,
   Sri Ramachandra University,
   Porur, Chennai- 600 116.

2. **Dr.Latha M.Sc.,(N), Ph.D., (N)**
   Professor & HOD,
   Department of Obstetrics & Gynecological Nursing,
   SRM College of Nursing,
   SRM University,
   Kattankulathur- 603 203.

3. **Dr.S.Rajeswari M.Sc.,(N), Ph.D., (N),**
   Associate Professor,
   Department of Obstetrics & Gynecological Nursing,
   Sri Ramachandra College of Nursing,
   Sri Ramachandra University,
   Chennai- 600 116.

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the data collection tool developed by **Mrs.P.Rosy,** M.Sc.(Nursing) II year student of Omayal Achi College of Nursing for her study **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Chennai, 2015",** is validated by the undersigned and she can proceed with this tool to conduct the main study.

Signature with date: S. Lalitha 9/2/16

Seal:

Dr. S. LALITHA, MBBS., DGO.
Regn. No: 28450
HOD (O & G)
Sir Ivan Stedeford Hospital
Ambattur, Chennai-600 053.

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the data collection tool developed by **Mrs.P.Rosy,** M.Sc.(Nursing) II year student of Omayal Achi College of Nursing for her study **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Chennai, 2015",** is validated by the undersigned and she can proceed with this tool to conduct the main study.

E. Sucharitha (71365)

Signature with date:

17/2/16

Seal:

Dr. E. SUCHARITHA, MBBS., DNB (O&G)., F.MAS.,
Reg. No: 71365
Consultant Obstetrician & Gynecologist,
Laparoscopic Surgeon

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the data collection tool developed by **Mrs.P.Rosy,** M.Sc.(Nursing) II year student of Omayal Achi College of Nursing for her study **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Chennai, 2015",** is validated by the undersigned and she can proceed with this tool to conduct the main study.

Signature with date: 5.1.Nov.

Seal:

Prof. Dr. S.J. NALINI, M.Sc., (N), P
Vice Principal
Faculty of Nursing
SRI RAMACHANDRA UNIVERSITY
Porur, Chennai-600 116

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the data collection tool developed by **Mrs.P.Rosy,** M.Sc.(Nursing) II year student of Omayal Achi College of Nursing for her study **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Chennai, 2015",** is validated by the undersigned and she can proceed with this tool to conduct the main study.

Signature with date: 3/5/16.

Seal:

Professor & HOD
Dept. of Obstetrics & Gynecology Nursing
SRM College of Nursing
SRM UNIVERSITY
Kattankulathur - 603 203,
Kancheepuram Dist., Tamil Nadu, India.

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the data collection tool developed by **Mrs.P.Rosy,** M.Sc.(Nursing) II year student of Omayal Achi College of Nursing for her study **"A Descriptive study to assess the Reproductive health problems among migrant women population at selected settings, Chennai, 2015",** is validated by the undersigned and she can proceed with this tool to conduct the main study.

Signature with date: 10/6/16.

Seal:

Dr. S. RAJESWARI
Associate Professor,
Faculty of Nursing
Sri Ramachandra University
Porur, Chennai-600

CERTIFICATE OF ENGLISH EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Ms.P.Rosy., M.Sc.Nursing II year student of Omayal Achi College of Nursing ,Chennai,conducted a dissertation work on **"A descriptive study to assess the Reproductive health problems among migrant women population at selected settings,Chennai"** under the guidance of Mrs.T.Amutha.,as a partial fulfillment of The Tamilnadu Dr.M.G.R.Medical University requirement for the award of M.Sc.Nursing degree is edited for English language appropriateness by J.VICTOR DHANARAJ

Signature with Date :

23.6.16

J. VICTOR DHANARAJ, M.A., B.Ed.,
SHREE JETHMAL TIKAMCHAND CHAIED
JAIN MISSION HIGHER SECONDARY SCHOOL
No. 1, NARAYANA MUDALI STREET,
CHENNAI - 600 079.

Seal :

CERTIFICATE OF TAMIL EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Ms.P.Rosy., M.Sc.Nursing II year student of Omayal Achi College of Nursing, Chennai, conducted a dissertation work on **"A descriptive study to assess the Reproductive health problems among migrant women population at selected settings,Chennai"** under the guidance of Mrs.T.Amutha.,as a partial fulfillment of The Tamilnadu Dr.M.G.R.Medical University requirement for the award of M.Sc.Nursing degree is edited for Tamil language appropriateness by A. NATARAJAN

Signature with Date:

A. NATARAJAN, M.A., B.Ed.,
B.T. TEACHER, (TAMIL)
P.U.M. SCHOOL, KUTHAMPOONDI,
VIKRAVANDI BLOCK,
Seal : VILUPURAM DISTRICT. 605 652

APPENDIX – E

INFORMED CONSENT

I understand that I am being asked to participate in a research study conducted by **Mrs. P. Rosy,** M.Sc. Nursing II year student of Omayal Achi College of Nursing. As I agree to participate in this study, I realize that I will be interviewed about Reproductive health problems.

I recognize that my participation in this study is entirely voluntary and I may withdraw from the study at any time as I wish.

I understand that all my study details will be kept confidential. I completely agree that these information can be used in nursing publication or presentations.

Signature/Thumb print of participant: **Date:**

Signature of Investigator: **Date:**

முன் அறிவிப்பு ஒப்பந்த படிவம்

உமையாள் ஆச்சி செவிலியர் கல்லூரியில் முதுநிலை இரண்டாம் ஆண்டு பயிலும் மாணவி **ம.ரோஸி** அவர்களால் நடத்த பெறும் இந்த ஆய்வில் என்னை பங்கேற்க கேட்டுக்கொண்டதை நான் ஏற்றுக் கொள்கிறேன். இந்த ஆய்வுக்கு நான் ஒப்புக் கொண்டதால், இதனைத் தொடர்ந்து இனப்பெருக்க சுகாதார சிக்கல்களை குறித்து கேள்விகள் கேட்கப்படும் என்பதை நான் அறிவேன்.

நான் யாருடைய கட்டாயத்தின் பெயரிலும் ஆய்வில் பங்கு கொள்ளவில்லை என்பதையும், தேவைப்பட்டால் நான் ஆய்விலிருந்து விலகிக் கொள்ளவும் எனக்கு முழு உரிமை உண்டு என்பதையும் அறிவேன்.

என்னைப் பற்றிய அனைத்து தகவல்களும் இரகசியமாக பாதுகாக்கப்படும் என்பதை அறிவேன். தேவைப்படும் போது ஆய்வின் முடிவுகள் செவிலியர் சார்ந்த பத்திரிகைகளிலும், கருத்தரங்குகளிலும் வெளியிட முழு சம்மதமும் அளிக்கிறேன்.

பங்கு கொள்ளுபவரின் கையொப்பம் / கைரேகை:

தேதி:

ஆய்வு நடத்துபவரின் கையொப்பம்:

தேதி:

APPENDIX – F

SECTION A: TOOL TO ASSESS THE REPRODUCTIVE HEALTH PROBLEMS OF MIGRANT WOMEN

DEMOGRAPHIC DATA

1)Age in years

1) 15-19
2) 20-24
3) 25-29
4) 30-34
5) 35-39
6) 40-44

2) What is your educational qualification?

1) Non-literate
2) Primary school
3) Elementary school
4) High school
5) Graduate and above

3) What is your Occupation?

1) Unemployed
2) Unskilled workers
3) Semi skilled worker
4) Skilled worker
5) Clericals, Shop owner
6) Semi Profession
7) Profession

4) How much is your Family income per month?

1) Rs 1803 – 5386/-

2) Rs 5387 – 8988/-
3) Rs 8989 – 13494/-
4) Rs 13495 – 17999/-
5) Rs 18000- 36016/-
6) Rs≥ 36017/-

5) Which type of family you belong to?

1) Nuclear
2) Joint
3) Extended
4) Other (specify)

6) What is your religion?

1) Hindu
2) Christian
3) Muslim
4) Others (specify)

7) What is your diet pattern?

1) Vegetarian
2) Non- vegetarian

8) Obstetrical score

A) Gravida

1) G1-G2
2) G3-G4
3) G5-G6
4) G7-G8
5) NIL

B) Para

1) P1-P2
2) P3-P4
3) P5-P6

4) P7-P8
5) NIL

C) Live birth

1) L1-L2
2) L3-L4
3) L5-L6
4) L7-L8
5) NIL

D) Abortion

1) A1-A2
2) A3-A4
3) A5-A6
4) NIL

E) The type of abortion

1) legal
2) Illegal
3) NA

MENSTRUAL HYGIENE

9) What is your duration of menstruation? (in days)

1) 3-5
2) 6-7
3) 8-9
4) 10-11

10) What type of napkins you prefer during menstruation?

1) Sanitary napkins
2) Waste cloths
3) Clean cloths
4) Others

11) How often do you the change sanitary pad or cloth?

1) Once a day
2) Twice a day
3) Thrice a day
4) More than three times

MARITAL HISTORY

12) What is your marital status?

1) Living with spouse
2) Separated
3) Divorced
4) Widow

13) What was your age at marriage (in years)

1) 15-17
2) 18-20
3) 21-23
4) 24-26

14) What is your duration of marital life (in completed years)

1) <5
2) 6-10
3) 11-15
4) 16-20
5) >20

15) What was your age at first child birth?

1) 14-17 years
2) 18-21 years
3) 22-24 years
4) 25-29 years

SEXUAL HISTORY

16) Can you mention the frequency of coitus with your husband?

1) Once a while
2) Weekly once
3) Two times a week
4) 3-4 times per week
5) More than 5 times

CONTRACEPTIVE HISTORY

17) Are you taking any contraceptive measures?

1) Yes
2) No

18) If yes,

1) Permanent method
2) Temporary method (specify)
3) NA

SECTION B: REPRODUCTIVE HEALTH PROBLEMS

MENSTRUAL IRREGULARITY

19) What is your age at menarche (in years)

1) 10-13
2) 14-16
3) 17-19
4) 20+

20) What is your menstrual cycle Pattern?

1) Regular
2) Irregular

21) If regular

1) 25 days once
2) 28 – 30 days once
3) 31 - 35 days once
4) 36 – 40 days once
5) NA

22) If irregular

1) Light or infrequent menstrual bleeding
2) Painful menstruation
3) Abnormal heavy bleeding
4) Frequent bleeding with shorting of menstrual cycle
5) NA

23) Do you follow any cultural health practices for above mentioned problems?

1) Yes
2) No

24) If yes,

1) Bland diet
2) Avoid Non-veg
3) Fenugreek seeds
4) NA

REPRODUCTIVE TRACT INFECTION

25) Do you have frequent raise of temperature?

1) Yes
2) No

26) Do you have back pain?

1) Yes
2) No
3)

27) History of white discharge?

1) Yes
2) No

28) What is the odour

1) Foul smell
2) Fishy smell
3) Pungent smelling
4) No odour
5) NA

29) What is the colour and consistency?

1) Clear with watery
2) Creamy white and sticky
3) Whitish with yellow
4) Yellow creamy white and thick
5) Gray to yellowish with offensive fishy smell
6) NA

30) How many times you get white discharge?

1) Daily

2) Mid menstrual period
3) 5 days before menstrual period
4) 5 days after menstrual period
5) NA

31) Is it itching in the perinea area?

1) Yes
2) No

32) If yes means specify

1) Desire to scratch the skin slightly
2) Scratches the skin often, redness, pricking sensation
3) Strong desire to itch the skin, swelling and burn
4) NA

33) Do you have any these problems in the perineal area?

1) Genital lesion
2) Genital injuries
3) Genital warts
4) Others
5) NA

34) Do you follow any cultural health practices for white discharge?

1) Yes
2) No

35) If yes,

1) White hibiscus flower
2) Fenugreek seeds
3) Basil leaves
4) NA

URINARY INCONTINENCE

36) Do you have incontinence of urine?

1) Yes

2) No

37) If yes,

1) Coughing
2) Sneezing
3) Physical activity - Mild activity
4) Strenuous activity
5) NA

ANEMIA

38) Do you experience the following signs and symptoms?

A) Feeling of tiredness

1) Yes
2) No

If yes means specify_____?

B) Shortness of breath

1) Yes
2) No

If yes means specify_____?

C) Palpitation

1) Yes
2) No

If yes means specify _____?

39) Leg swelling

1) Yes
2) No

40) If yes means

1) Grade I
2) Grade II
3) Grade III

4) Grade IV
5) NA

Edema assessment scale (Emilyslone, Susan)

S.No.	CHARACTERISTICS	GRADE
1.	Minimal edema of lower extremities	+1
2.	Marked edema of lower extremities	+2
3.	Edema of lower extremities , face, hands and sacral area	+3
4.	Generalized massive edema that include ascites	+4

41) Assess the colour of the conjunctiva _____?

1) Pink in colour
2) Pale in colour

42) Colour of thefinger nails _____

1) Pink in colour
2) Pale in colour

43) Shape of the nail _____

1) Spoon
2) Clubbing
3) Brittle nails
4) NA

44) Do you follow any other cultural practices for above mentioned symptoms _____?

1) Yes
2) No

45) If yes,

1) Having green leaf vegetables
2) Jaggery
3) Groundnuts
4) NA

46) Do you take dewarmimg tablet once in 6 months?

1) Yes
2) No

BREAST PROBLEMS

47) Do you have breast problems?

1) Yes
2) No

48) A lump

1) Yes
2) No

49) Swelling

1) Yes
2) No

50) Pain

1) Yes
2) No

51) Nipple retraction and Dimpling

1) Yes
2) No

52) Redness of the nipple or breast skin

1) Yes
2) No

53) Scaly nipple or breast skin

1) Yes
2) No

54) Skin irritation

1) Yes
2) No

55) Nipple discharge

1) Yes
2) No

56) Any family history of breast problems?

1) Yes
2) No

57) If yes , type of problem and relationship

1) Mastalgia
2) Lump
3) Breast cancer
4) Nipple discharge
5) NA

நரிக்குறத்திகளுக்கு ஏற்படும் இனப்பெறுக்க சுகாதார சிக்கல்கள் குறித்த தரவு சேகரிப்பு கருவிகள்

பகுதி - அ

பொதுவானவிவரம்

1. உங்களுடைய வயது (முழுமைப் பெற்றது)
    1) 14-16
    2) 17-18
    3) 19-21
    4) 22-26
    5) 27-36
    6) 37-44

2. உங்களுடைய கல்வி தகுதி
    1) படிக்கவில்லை
    2) ஆரம்பப்பள்ளி
    3) தொடக்கப் பள்ளி
    4) உயர்நிலைப்பள்ளி
    5) பல்கலைக்கழுகப் பட்டம்

3. உங்களுடைய தொழில்
    1) வேலையில்லாதவர்
    2) திறமையற்ற வேலைக்காரர்
    3) பாதி திறமையான தொழிலாளர்
    4) தேர்ச்சியுடைத் தொழிலாளர்
    5) கடைமுதலாளி
    6) பாதி உத்தியோகம் செய்பவர்
    7) உத்தியோகம் செய்பவர்

4. உங்களுடைய மாத வருமானம்
    1) ரூ. 1803 - 5386/-
    2) ரூ. 5387 - 8988/-

3) ரூ. 8988 - 13494/-

4) ரூ. 13495 - 17999/-

5) ரூ. 18000 - 36016/-

6) ரூ. 36017/-

5. நீங்கள் எந்த வகை குடும்பத்தைச் சார்ந்தவர்கள்

1) தனிக் குடும்பம்

2) கூட்டுக் குடும்பம்

3) விரிவுப்படுத்தப்பட்ட குடும்பம்

4) மற்றவை

6. உங்களுடைய மதம்

1) இந்து

2) கிறித்துவம்

3) முஸ்லீம்

4) மற்றவை (குறிப்பிடம்)

7. நீங்கள் எந்த வகையான உணவு தேர்ந்தெடுப்பீர்கள்?

1) சைவ உணவு

2) அசைவ உணவு

8. மகப்பேறு மதிப்பு **G P L A S D**

அ) மகப்பேறு நிலை

1. $G_1 - G_2$

2. $G_3 - G_4$

3. $G_5 - G_6$

4. $G_7 - G_8$

5. *எதுவும் இல்லை*

ஆ) கர்ப்பகால நிலை

1. $P_1 - P_2$

2. $P_3 - P_4$

3. $P_5 - P_6$

4. $P_7 - P_8$

5. *எதுவும் இல்லை*

இ) உயிருடன் பிறந்த குழந்தை எண்ணிக்கை

1. $L_1 – L_2$

2. $L_3 – L_4$

3. $L_5 – L_6$

4. $L_7 – L_8$

5. *எதுவும் இல்லை*

ஈ) கருச்சிதைவு நிலை

1. $A_1 – A_2$

2. $A_3 – A_4$

3. $A_5 – A_6$

4. *எதுவும் இல்லை*

9. உங்களுக்கு கருச்சிதைவு ஏற்ப்பட்டுயிருக்கா?

1) ஆம்

2) இல்லை

10. ஆம், என்றல் எத்தனை முறை, எந்த வகை கருச்சிதைவு மற்றும்

1. சட்டப்படி?

2. சட்டத்திற்கு புறம்பாக நடந்திருக்கிறதா?

மாதவிடாய் சுகாதாரம் :

11. உங்களுடைய மாதவிடாய் சுழற்சியின் காலம் என்ன?

1) 3 - 5 நாட்கள்

2) 6 - 7 நாட்கள்

3) 8 - 9 நாட்கள்

4) 10 - 11 நாட்கள்

12. நீங்கள் மாதவிடாயின் போது எந்த வகையான துணியை ஆய்ந்தெடுத்து பயன்படுத்துவீர்கள்?

1) சானிடர்நாப்கின்

2) கந்தல் துணி (தூய்மையற்ற)

3) தூய்மையான துணி

4) மற்றவை

13. நீங்கள் எப்போதெல்லாம் மாதவடாயின் போது பயன்படுத்தும் துணியை மாற்றுவீர்கள்?

1) ஒரு நாளில் ஒரு முறை

2) ஒரு நாளில் இரண்டு முறை

3) ஒரு நாளில் மூன்று முறை

4) மூன்று முறை மேல்

திருமணம் விவரம் :

14. உங்களுடைய திருமணநிலை?

1) கணவருடன் வாழ்வது

2) தனித்து வாழ்வது

3) விவாகரத்தான

4) விதவை

15. திருமணத்தின் போது உங்களுடைய வயது என்ன?

1) *15-17*

2) *18-20*

3) *21-23*

4) *24-26*

16. உங்களுடைய திருமண கால அளவு (முழுமையான வருடம்)

1) > 5

2) *6-10*

3) *11-15*

4) *16-20*

5) > 20

17. முதல் பிரசவத்தின் போது உங்களின் வயது என்ன?

1) 14-17

2) *18-21*

3) *22-24*

4) *25-29*

உடலுறவு பற்றிய விவரம்

18. நீங்கள் உங்கள் கணவருடன் எத்தனை முறை உடலுறவுக் கொள்வீர்கள்?

1) எப்பொழுதாவது ஒரு முறை

2) வாரத்தில் ஒரு முறை

3) வாரத்தில இரண்டு முறை

4) வாரத்தில் *3-4* முறை

5) வாரத்தில் *5* முறைக்கு மேல்

கருத்தடைச் சாதனம் பற்றிய விவரம்

19. நீங்கள் கருத்தடை சாதன முறையை பயன்படுத்துகிறீர்கர்களா?

1) ஆம்

2) இல்லை

20. ஆம்,என்றல்

1) நிரந்தரமுறை

2) தற்காலிகமுறை

3) எதுவும் இல்லை

பகுதி - ஆ

இனப்பெருக்க சுகாதாரச் சிக்கல்கள்

1 ஒழுங்கற்ற மாதவிடாய் சுழற்றி

21. நீங்கள் பூப்படையும் போது என்ன வயது

1) *10-13*

2) *14-16*

3) *17-19*

4) >20

22. உங்களுடைய மாதவிடாய் சுழற்றி

1) *ஒழுங்கானது*

2) *ஒழுங்கற்றது*

23. ஒழுங்கானதுஎன்றால்

1) *25 நாட்களுக்கு ஒரு முறை*

2) *28 - 30 நாட்களுக்கு ஒரு முறை*

3) *31 - 35 நாட்களுக்கு ஒரு முறை*

4) *36 - 40 நாட்களுக்கு ஒரு முறை*

5) *எதுவும் இல்லை*

24. ஒழுங்கற்றது என்றால்

1) *குறைவான அல்லது இடைகிடை மாதவிடாய்*

2) *மாதவிடாயின் போது கடுமையான வலி*

3) *அதிகப் இரத்தப் போக்கு*

4) *அசாதாரணமான புணாபுழை இரத்த ஒழுக்கமுறை*

5) *எதுவும் இல்லை*

25. நீங்கள் மாதவிடாய் சிக்கல்களின் போது, கலாச்சார மற்றும் சுகாதாரநடை முறைகளை பயன்படுத்துவீர்களா?

1. *காரமில்லாத உணவு வகை*

2. *அசைவ உணவை தவிர்ப்பது*

3. *வெந்தயத்தை எடுத்தல்*

4. *எதுவும் இல்லை*

2 . இனப்பெருக்கத்தடத் தொற்று:

26. உங்களுக்கு அடிக்கடி காய்ச்சல் வருகிறதா?

1) ஆம்
2) இல்லை

27. உங்களுக்கு முதுகுவலி இருக்கிறதா?

1) ஆம்
2) இல்லை

28.உங்களுக்கு வெள்ளைப்படுதல் பிரச்சனை உள்ளதா?

1) ஆம்
2) இல்லை

29. வெள்ளைப்படும் போது அதுனுடைய வாசனை என்ன?

1) துர்நாற்றம் வாசனை
2) மர்மான வாசனை
3) கூர்மையான உறைப்பான வாசைன
4) வாசனை இல்லை

30. வெள்ளைபடுதலின் நிறம் மற்றம் நிலைத்தன்மை என்ன?

1) தெளிவான மற்றும் தண்ணீர் போன்ற
2) வெண்ணை போன்ற ஒட்டும் தன்மை
3) வெண்மையுடன் கலந்த மஞ்சல் நிறம் போன்ற
4) மஞ்சல் வெண்மை போன்ற மற்றும் ஒட்டும் தன்மையுள்ள
5) சாம்பல் முதல் மஞ்சல் போன்ற மற்றும் மர்மமான தூர்நாற்றம்

31. எப்போதெல்லாம் உங்களுக்கு வெள்ளைப்படுதல் இருக்கும்?

1) தினமும்
2) இடைப்பட்ட மாதவிடாய் காலத்தின் போதும்
3) மாதவிடாய்க்கு முன்பு 5 நாட்கள்
4) மாதவிடாய்க்கு பிறகு 5 நாட்கள்

32. இம்மாதிரி அப்பகுதியில் உங்களுக்கு அரிப்பு இருக்கிறதா?

1) ஆம்
2) இல்லை

33. ஆம், என்றால்,

1) லேசாகதோல் அரிப்புஉள்ளது

2) தோல் பகுதியில் அடிக்கடி அரிப்புமற்றும் சிவந்த வண்ணம் மற்றும் குற்றம் நன்மையுள்ள

3) அதிக பிறப்புறுப்பில் தோல் பகுதியில் அரிப்பு மற்றும் எரிச்சல் மற்றம் வீக்கம்

4) எதுவும் இல்லை

34. உங்களுக்கு இம்மாதிரியான சிக்கள்கள் உண்டா?

1) பிறப்பிறுப்பு தோல் பிரச்சனைகள்

2) பிறப்பிறுப்பில் காய்ங்கள்

3) இனப்பெருக்க மருக்கள்

4) எதுவும் இல்லை

35. நீங்கள் வெள்ளைப்படுதலின் போது கலாச்சார மற்றும் சுகாதார நடைமுறைகளை பயன்படுத்துவீர்களா?

1) வெள்ளை செம்பருத்திப் பூ உண்ணுதல்

2) வெந்தயம் உண்ணுதல்

3) துளசி உண்ணுதல்

4) எதுவும் இல்லை

3. சிறுநீர் அடக்க இயலாமை

36. உங்களுக்கு சிறுநீர் அடக்க இயலாமை பிரச்சனை உள்ளதா?

1) ஆம்

2) இல்லை

37. ஆம் என்றால்

1. இரும்பும் போது

2. தும்பும் போது

3. வேலை செய்யும் போது

4. சாதாரண வேலை

5. விறுவிறுப்பான வேலை

4. இரத்தச்சோகை

38. உங்களுக்கு தொடர்ந்து இத்தகைய அறிகுறிகள் மற்றம் அடையாளங்கள் உள்ளவனவா?

1) சோர்வாக உணர்கிறீர்களா?

1) ஆம்

2) இல்லை

ஆம் என்றால் எப்போது?

2) மூச்சு திணறல் பிரச்சனை உள்ளதா?

1) ஆம்

2) இல்லை

ஆம் என்றால் எப்போது

3) இதயத்துடிப்பு அதிகமாக உள்ளதா?

1) ஆம்

2) இல்லை

ஆம் என்றால் எப்போது

39. பாதத்தில் வீக்கம் உள்ளதா?

1) ஆம்

2) இல்லை

40. ஆம் என்றால்

1) தரப்படுத்தி 1

2) தரப்படுத்தி 2

3) தரப்படுத்தி 3

4) தரப்படுத்தி 4

உடலில் நீர் வீக்கம் மதிப்பீடு (எமிலி ஸ்லோன் சூசன் 2001)

வா.எண்	தன்மை	மதிப்பீடு
1	பாதத்தில் மட்டும் மிகச்சிறிய வீக்கம்	+ 1
2	குறிப்பிட்ட பாதத்தில் நீர் வீக்கம்	+ 2
3	நீர்வீக்கம், பாதத்தில், கால்களில், கைகள், முகத்தில் மற்றும் இடுப்பு பகுதியில்	+ 3
4	பொதுவான நீர் வீக்கம் மற்றும் வயிறு வீக்கம்	+ 4

41) கண்ணின் நிறம் மதிப்பீடு

1) இளஞ்சிவப்பு நிறம்
2) வெளிர் போன்ற நிறம்

42) விரல் நகத்தின் நிறம்

1) இளஞ்சிவப்பு நிறம்
2) வெளிர் போன்ற நிறம்

43) விரல் நகத்தின் வடிவம்

1) கரண்டி போன்ற வடிவம்
2) தடித்த மற்றும் சாய்வான வடிவம்
3) முறியத்தக்க வடிவம்

44). நீங்கள் உடலில் உள்ள பூச்சியை நீக்க மருத்துவரிடம் அம் மருத்தை எடுக்கும் பழக்கம் உள்ளவரா?

1) ஆம்
2) இல்லை

45) நீங்கள் மேலே குறிப்பிட்ட பிரச்சனைகளுக்கு கலாச்சார மற்றும் சுகாதார நடைமுறைகளை பயன்படுத்துகீறீர்களா?

1) ஆம்
2) இல்லை

46) ஆம் என்றால்

1) *பச்சை காய்கறிகள் உண்ணுதல்*

2) *முருங்ககீரை உண்ணுதல்*

3) *வேர்கடலை உண்ணுதல்*

4) *எதுவும் இல்லை*

5. மார்பக சிக்கல்கள்

47) உங்களுக்கு மார்பக சிக்கல்கள் உள்ளதா?

1) *ஆம்*

2) *இல்லை*

48) கட்டிபோன்ற

1) *ஆம்*

2) *இல்லை*

49) வீக்கம்

1) *ஆம்*

2) *இல்லை*

50) சீறுகுழிவு மற்றும் பின்னோக்கிய காம்பு போன்ற

1) *ஆம்*

2) *இல்லை*

51) வலி

1) *ஆம்*

2) *இல்லை*

52) சிவந்தநிற காம்பு (அ) மார்பக தோல்

1) *ஆம்*

2) *இல்லை*

53) செதிர் போன்ற தோல் பகுதி (மார்பகம், காம்பில்)

1) *ஆம்*

2) *இல்லை*

54) தோல் எரிச்சல்

1) ஆம்

2) இல்லை

55) காம்பில் திரவம் வடிதல்

1) ஆம்

2) இல்லை

56. உங்கள் குடும்பத்தில் மார்பக பிரச்சனை யாருக்கேனும் உண்டா?

1) ஆம்

2) இல்லை

*57.*ஆம் என்றால்,

1) மார்பகவீக்கம்

2) மார்பகபுற்றுநோய்

3) காம்பில் சீல் வடிதல்

4) எதுவும் இல்லை

APPENDIX – G

I. CODING FOR DEMOGRAPHIC VARIABLES

PART A. DATA COLLECTION TOOL

SECTION – A: DEMOGRAPHIC DATA

1) Age in years ----------
    1) 15-19 1
    2) 20-24 2
    3) 25-29 3
    4) 30-34 4
    5) 35-39 5
    6) 40-44 6

2) What is your educational qualification?
    1) Non-literate 1
    2) Primary school 2
    3) Elementary school 3
    4) High school 4
    5) Graduate and above 5

3) What is your Occupation?
    1) Unemployed 1
    2) Unskilled workers 2
    3) Semi skilled worker 3
    4) Skilled worker 4
    5) Clericals, Shop owner 5
    6) Semi Profession 6
    7) Profession 7

4) How much is your Family income per month?
    1) Rs 1803 – 5386/- 1
    2) Rs 5387 – 8988/- 2
    3) Rs 8989 – 13494/- 3

4) Rs 13495 – 17999/- 4
5) Rs 18000- 36016/- 5
6) Rs≥ 36017/- 6

5) Which type of family you belong to?

1) Nuclear 1
2) Joint 2
3) Extended 3
4) Other (specify) 4

6) What is your religion?

1) Hindu 1
2) Christian 2
3) Muslim 3
4) Others (specify) 4

7) What is your diet pattern?

1) Vegetarian 1
2) Non- vegetarian 2

8) Obstetrical score

A) Gravida

1) G1-G2 1
2) G3-G4 2
3) G5-G6 3
4) G7-G8 4
5) NIL 5

B) Para

1) P1-P2 1
2) P3-P4 2
3) P5-P6 3
4) P7-P8 4
5) NIL 5

C) Live birth

1) L1-L2 1
2) L3-L4 2
3) L5-L6 3
4) L7-L8 4
5) NIL 5

D) Abortion

1) A1-A2 1
2) A3-A4 2
3) A5-A6 3
4) NIL 4

E) The type of abortion

1) Legal 1
2) Illegal 2
3) NA 3

APPENDIX – H

BLUE PRINT

S.No.	Content	Item	Total item	Percentage
1	Demographic variables	1-8	8	14.0
	Clinical variables	9-18	10	17.5
II	**Structured interview schedule**			
	• Menstrual irregularity	19-24	6	10.5
	• Reproductive tract infection	25-35	11	19.2
	• Urinary incontinence	36-37	2	3.5
	• Anemia	38-46	9	15.7
	• Breast problems	47-57	11	19.6
		Total	**57**	**100**

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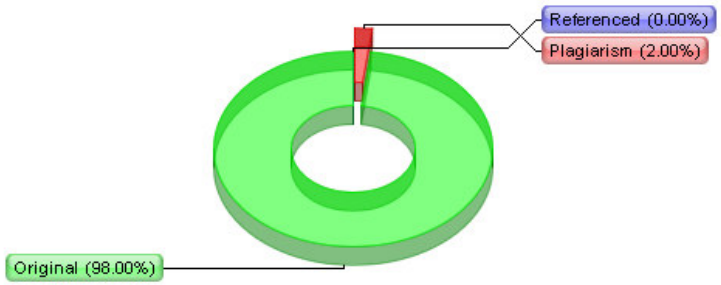

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APPENDIX – J

DISSERTATION EXECUTION PLAN – GANTT CHART

GANNT CHART																			
S.NO	**CALANDER MONTHS**	**Mar 15**	**Apr '15**	**May '15**	**June '15**	**July '15**	**Aug '15**	**Sep `15**	**Oct '15**	**Nov '15**	**Dec '15**	**Jan '16**	**Feb '16**	**Mar '16**	**Apr '16**	**May '16**	**June '16**	**July '16**	**Aug '16**
A	**Conceptual phase**																		
1	**Problem identification**																		
2	**Literature review**																		
3	**Clinical fieldwork**																		
4	**Theoretical framework**																		
5	**Hypothesis formulation**																		
B	**Design & planning phase**																		
6	**Research design**																		
7	**Intervention protocol**																		
8	**Population specification**																		
9	**Sampling plan**																		
10	**Data collection plan**																		
11	**Ethics procedure**																		
12	**Finalization of plans**																		
C	**Empirical phase**																		
13	**Data collection**																		
14	**Data preparation**																		
D	**Analytical phase**																		
15	**Data analysis**																		
16	**Interpretation of results**																		
E	**Dissemination phase**																		
17	**Presentation or report**																		
18	**Utilization of findings**																		
	Calendar months	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**